NHS
Forth Valley

A meeting of the **Forth Valley NHS Board** will be held on **Tuesday 28 April 2026** at **9.30am** in the **Boardroom, Carseview House, Castle Business Park, Stirling FK9 4SW**.

Neena Mahal
Chair

AGENDA

1.	**Welcome, Apologies and Confirmation of Quorum**		**09.30**
2.	**Declaration(s) of Interest(s)**		
3.	**(a)** **Minute of Forth Valley NHS Board meeting held on 24 February 2026, and** **(b)** **Minute of Forth Valley NHS Board meeting held on 31 March 2026**	For Ratification **Pages 6 to 19** **Pages 20 to 27**	
4.	**Matters Arising from the Minute / Action Log**	For Approval **Pages 28 to 32**	
5.	**Chair's Report** (a) Verbal Update by Ms Neena Mahal, Board Chair (b) Highlight Report on Board Seminars	For Assurance For Information **Page 33**	**9.40**
6.	**Board Executive Team Report** (Paper presented by Professor Ross McGuffie, Chief Executive)	For Discussion **Pages 34 to 39**	**9.50**
	7. COMMITTEE MINUTES AND AN OPPORTUNITY FOR COMMITTEE CHAIRS TO HIGHLIGHT MATERIAL ISSUES TO THE BOARD		**10.00**
	Governance Committee Minutes		
7.1	**Audit & Risk Committee –Meeting of 27 March 2026 – Verbal Update** (Presented by Cllr Fiona Collie, Committee Chair)	For Assurance	
7.2	**Clinical Governance Committee – Meeting of 17 March 2026 – Verbal Update** (Presented by Mr John Stuart, Committee Chair)	For Assurance	
7.3	**Staff Governance Committee – Minute of Meeting of 20 January 2026 and Verbal Update from meeting of 10 March 2026** (Presented by Mr Martin Fairbairn, Committee Chair)	For Assurance **Pages 40 to 50**	
7.4	**Strategic Planning, Performance & Resources Committee – Minute of Meeting of 31 March 2026** (Presented by Ms Neena Mahal, Committee Chair)	For Assurance **Pages 51 to 67**	
	Advisory Committee Minutes		
7.5	**Area Clinical Forum – Verbal Updates from the Meetings of 15 January and 23 April 2026** (Presented by Mrs Kirstin Cassells, ACF Chair)	For Noting	

7.6	**Area Partnership Forum – Minute of Meeting of 17 February 2026** (Presented by Mrs Karren Morrison, APF Co-Chair)	For Noting **Pages 68 to 72**	
	INTEGRATION JOINT BOARDS		
7.7	**Minutes of Clackmannanshire & Stirling Integration Joint Board – 28 January 2026 and 27 February 2026 and Direction**	For Assurance **Pages 73 to 91**	
7.8	**Minute of Falkirk Integration Joint Board – 30 January 2026**	For Assurance **Pages 92 to 98**	
	FOR APPROVAL		
8.	**Strategic Risk Register Update – February 2026 to April 2026** (Paper presented by Ms Vicky Webb, Head of Risk Management)	For Decision **Pages 99 to 124**	**10.30**
9.	**Risk Management Framework** (Paper presented by Ms Vicky Webb, Head of Risk Management)	For Decision **Pages 125 to 144**	
10.	**Communications Update for 2025/26 and Key Plans and Priorities for 2026/27** (Paper presented by Ms Elsbeth Campbell, Head of Communications)	For Decision **Pages 145 to 159**	**11.00**
	BREAK 11.25 to 11.40		
11.	**Code of Corporate Governance – Annual Review** (Paper presented by Mr Jack Frawley, Board Secretary)	For Decision **Pages 160 to 371**	**11.40**
	FOR DISCUSSION & ASSURANCE		
	Quality & Safety		
12.	**Update on Safety:** **(a) Quality Assurance and Improvement Report** (Paper presented by Mr Andrew Murray, Medical Director and Professor Karen Goudie, Executive Nursing Director) **(b) Healthcare Associated Infection (HAI) Report April 2025** (Paper presented by Mr Jonathan Horwood, Infection Control Manager & Clinical Lead)	For Assurance **Pages 372 to 388** **Pages 389 to 413**	**11.55**
13.	**Health and Care Staffing (Scotland) Act - Annual Report** (Paper presented by Professor Karen Goudie, Executive Nursing Director)	For Assurance **Pages 414 to 498**	**12.25**
14.	**Spotlight on Services – Allied Health Professions** (Paper presented by Professor Karen Goudie, Executive Nurse Director)	For Assurance **Pages 499 to 505**	**12.40**
	Finance & Performance		
15.	**Finance Report** (Paper presented by Mr Scott Urquhart, Director of Finance)	For Assurance **Pages 506 to 513**	**1.00**
16.	**Performance Report** (Paper presented by Ms Kerry Mackenzie, Acting Director of Strategic Planning & Performance)	For Assurance **Pages 514 to 569**	**1.10**

17.	**Schedule of Business**	For Information **Pages 570 to 571**	
18. ANY OTHER COMPETENT BUSINESS			
19. RISKS AND REFLECTIONS			
20.	**Date and Time of Next Meeting** Tuesday 25 August, 9.30am	For Noting	

Forth Valley NHS Board
Record of Attendance: 1 April 2025 to 31 March 2026

MEMBERS	29 Apr	27 May	17 June	29 July	30 Sept	25 Nov	27 Jan	24 Feb	31 March
Neena Mahal (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kirstin Cassells	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jennifer Champion (from 10 September)					✓	✓	✓	✓	X
Robert Clark (until 27 Feb)	✓	✓	✓	✓	✓	✓	✓	✓	
Fiona Collie	✓	X	✓	✓	✓	✓	X	✓	✓
Frances Dodd (demitted office 15 July 2025)	✓	✓	X						
Martin Fairbairn	✓	✓	✓	✓	✓	✓	✓	X	✓
Karen Goudie (from 16 July 2025)				✓	X	✓	✓	✓	✓
Alison Jaap				✓	✓	✓	X	✓	✓
Gordon Johnston	✓	✓	✓	✓	✓	✓	✓	✓	✓
Fiona Law	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stephen McAllister	✓	✓	✓	✓	✓	✓	✓	✓	X
Ross McGuffie	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clare McKenzie				✓	✓	✓	✓	✓	✓
Karren Morrison (from 2 March)									✓
Andrew Murray	✓	✓	✓	✓	✓	✓	✓	✓	X

Allan Rennie	✓	✓	X	✓	✓	✓	✓	✓	✓
Finlay Scott				X	✓	✓	✓	✓	✓
John Stuart	✓	✓	✓	✓	✓	✓	✓	✓	✓
Scott Urquhart	✓	✓	✓	✓	✓	✓	✓	✓	X
David Wilson (until 30 November)	✓	✓	X	✓	✓	X			

Key:

✓ In attendance
X Apologies
O Non-attendance

FORTH VALLEY NHS BOARD

3a. Minute of the Forth Valley NHS Board Meeting held on Tuesday 24 February 2026
For: Ratification

Minute of the Forth Valley NHS Board Meeting held on Tuesday 24 February 2026 at 9.30am in the Boardroom, Carseview House.

Present:
Ms Neena Mahal (Board Chair)
Ms Kirstin Cassells (Non-Executive Director)
Dr Jennifer Champion (Director of Public Health) left meeting at 10.30, rejoined at 11.50
Mr Robert Clark (Non-Executive Director)
Cllr Fiona Collie (Non-Executive Director)
Cllr Scott Farmer (Non-Executive Director)
Professor Karen Goudie (Executive Nurse Director)
Ms Alison Jaap (Non-Executive Director)
Mr Gordon Johnston (Non-Executive Director)
Cllr Fiona Law (Non-Executive Director)
Mr Stephen McAllister (Non-Executive Director)
Professor Ross McGuffie (Chief Executive)
Professor Clare McKenzie (Non-Executive Director)
Mr Andrew Murray (Medical Director)
Mr Allan Rennie (Vice Chair)
Mr Finlay Scott (Non-Executive Director)
Mr John Stuart (Non-Executive Director)
Mr Scott Urquhart (Director of Finance)

In Attendance:
Ms Jennifer Borthwick (Interim Chief Officer, Clackmannanshire & Stirling IJB)
Ms Elsbeth Campbell (Head of Communications)
Mrs Morag Farquhar (Director of Facilities)
Mr Garry Fraser (Director of Acute Services)
Mr Jack Frawley (Board Secretary)
Mr Scott Jaffray (Director of Digital)
Ms Kerry Mackenzie (Acting Director of Strategic Planning, Performance & Resources)
Ms Jackie McEwan (Corporate Business Manager)
Ms Linda McGovern (Deputy Director of Workforce)
Ms Gail Woodcock (Chief Officer, Falkirk IJB)
Mr Adewale (Vice Chair of the Ethnic Diversity Network - Item 8)
Ms Rachel Tardito (Equality, Diversity & Wellbeing Lead – Item 8)
Mr David Logie (Head of Procurement – Item 12)

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1. Welcome, Apologies for Absence and Confirmation of Quorum
An apology was intimated on behalf of Martin Fairbairn. The Board meeting was quorate.

Laura Byrne and Kevin Reith were not in attendance.

2. Declarations of Interest
There were no declarations of interest.

3. Minute of Meeting

The minute of the meeting held on 27 January 2026, subject to previous electronic circulation and Board member approval, was **confirmed** as a correct record.

4. Matters Arising from the Minute / Action Log

The Action Log was **reviewed** by the Board Chair and consideration was given to the actions still in progress.

Board members noted that actions 114 and 118 were marked as complete and would be removed from the Action Log.

An update was sought on action 070. The Falkirk Integration Scheme had been updated following receipt of Scottish Government feedback and resubmitted. Confirmation had been received that the revised Scheme had been received by Scottish Government but there was no exact timeline for approval. The impact of the upcoming Scottish Parliament elections on the approval process was noted. Work continued to progress on the Clackmannanshire & Stirling Integration Scheme, with the outstanding area of work being in relation to the Risk Share arrangements.

With reference to action 118 it was noted that comments on the Patient Centred Care Report should be sent outwith the meeting if required.

The Forth Valley NHS Board approved the Action Log.

5.

(a) Chair's Report - Verbal Update by Ms Neena Mahal

The Board Chair highlighted the following:

(a) The Chair had undertaken a number of visits with the Chief Executive including to Cardiology and Maternity.
(b) Christine McLaughlin had visited the Emergency Department, received a presentation on Shifting the Balance of Care and discussed challenges around ED performance.
(c) There had been a number of key events to which Non-Executive Board Members had been invited, including the NMAHP Leadership Event. There would be further sessions of the NMAHP Leadership Event in the future.
(d) The Board Chair had attended the Quality Team Huddle and noted that there was a Board Seminar on Quality on 3 March 2026.
(e) It was highlighted that the Board and Committees Effectiveness Surveys would shortly close and any outstanding responses were encouraged.
(f) Upcoming Board events were noted included the Seminar on 3 March covering the Financial Plan and Quality, and a Culture Programme session on 9 March.

The Forth Valley NHS Board noted the update from the Board Chair.

(b) Board Seminar Update

The Forth Valley NHS Board noted for information the Board Seminar Update report on the session held on 10 February 2026 on the draft Financial Plan; Corporate Objectives, and Corporate Parenting.

6. Board Executive Team Report

The Forth Valley NHS Board considered the Board Executive Team report, presented by Professor McGuffie, which provided an update on service areas celebrating success, key areas of activity by the Senior Leadership Team, and upcoming issues.

Key messages in the report included:

(i) An article had recently been published in the BMJ Leader on the FVRH's national Simulation Centre.

(ii) The Cabinet Secretary for Health & Social Care was due to attend the launch of the local Macmillan Improving the Cancer Journey programme in Forth Valley which would take place at the University of Stirling on 25 February, highlighting the services and support available including the Macmillan one-to-one service which had been in place for several years.

(iii) The Chief Executive of NHS Scotland visited the Acute Frailty Unit to meet staff and hear how the service provided early access to comprehensive geriatric assessments, using a multidisciplinary and holistic approach to help identify each patient's individual goals.

(iv) The following teams had been confirmed as finalists in this year's RCN Scotland Nurse of the Year Awards in the Nursing Team of Year category:
- NHS Forth Valley Prison Health Care Teams – three national prisons
- Specialist Rehabilitation Unit, Bellfield Centre, Stirling Health and Care Village

(v) A Research and Innovation Collaboration session was being held on 5 March 2026 to help overcome obstacles to collaboration, followed by dynamic five-minute pitches presented by partners across the network to inspire new opportunities and connections.

(vi) The HIS inspection report on Mental Health Services was published at the end of January. The report observed staff treating patients with compassion, but noted the need for strengthened risk assessment, clearer assurance processes, staff governance and environmental improvements. An action plan had been developed to ensure all improvements identified were implemented in a timely manner, with oversight from the Clinical Governance Committee.

(vii) The Director of Public Health had been working closely with national colleagues in support of the new Sub-National Planning Committees, with the aim of ensuring a population health focus across the four key workstreams set out within the Director's Letter.

The following points were made in discussion:

(i) Members asked when an evaluation and impact report from the Frailty Unit would be presented. The information for evaluation would be pulled together at the end of the financial year. There had been a number of concurrent developments, including Shifting the Balance of Care and Hospital at Home where the collective impact would be seen. The Frailty Unit was now nearly at seven day a week operation. The Executive was keen to look at a connected community frailty pathway.

(ii) Information was sought on any early impacts from the sub-national work. Governance remained with individual Boards and was not intended to change. Forth Valley's Board Chair and Chief Executive attended the SPDC West on a monthly basis. The Chief Executive and a number of other Forth Valley Executive Directors were involved with sub-groups. It was noted that Staff Side continued to advocate for involvement in the sub-national work.

The Forth Valley NHS Board noted the report.

Committee Minutes

7.1 Audit & Risk Committee – 23 January 2026

Key items had previously been highlighted at the January Board meeting. The minute was commended to the Board for noting.

A question was asked on internal audit annual planning processes and the role of the Board in that. The work plan was a collaborative process with a set number of audit days available to Forth Valley. These targeted key strategic risks, standard areas and priorities raised locally. Forth Valley had influence over the discretionary days. The prioritisation of these days was considered by SLT and then approved at Audit & Risk Committee who had an opportunity to review the proposed workplan.

The Forth Valley NHS Board noted the minute of the meeting of the Audit & Risk Committee of 23 January 2026.

Action

(i) Consider the process of Committee Member engagement in development of the Internal Audit workplan. Scott Urquhart/Fiona Collie

7.2 Clinical Governance Committee – 13 January 2026

Key items had previously been highlighted at the January Board meeting. The minute was commended to the Board for noting.

The Forth Valley NHS Board noted the minute of the Clinical Governance Committee meeting of 13 January 2026.

Advisory Committee Minutes:

7.3 Area Partnership Forum – 16 December 2025

Key items had previously been highlighted at the January Board meeting. The minute was commended to the Board for noting.

The Forth Valley NHS Board noted the minute of the Area Partnership Forum of 16 December 2025.

7.4 The Minute of Clackmannanshire & Stirling Integration Joint Board – 26 November 2025 was noted for information.

7.5 The Minute of the Falkirk Integration Joint Board – 5 December 2025 was noted for information.

Action

(i) Circulate the link to the Health & Sport Committee debate on IJB Voting Rights Extension to Board Members. Jack Frawley.

8. Anti-Racism Plan and Communications Plan

The Forth Valley NHS Board considered a report for approval, presented by Ms McGovern and supported by Mr Adewale, Vice Chair of the Ethnic Diversity Network and Ms Rachel Tardito, Equality, Diversity and Wellbeing Lead, which set out the draft Forth Valley Anti-Racism Plan which had been developed through partnership work and engagement. It was noted that Board Members had been engaged throughout the development of the Plan with the opportunity to provide comment. A previous version had been presented to SPPRC for comment.

Key messages in the report included:

(i) The Plan established a clear and proportionate approach to addressing racism across the workforce, services, and organisational culture. It was informed by national policy, local data, and lived experience, and was aligned with the Equality Act (2010) and NHS Scotland values.

(ii) The Plan was supported by an Equality Impact Assessment, a delivery tool, and communications and launch plan.

(iii) The Plan outlined an ambitious yet achievable three-year programme of work, underpinned by robust collaboration with the Ethnic Diversity Staff Network, trade unions, and community stakeholders.
(iv) The Plan set out six objectives which were:
    1. Ensure Visible Leadership and Shared Accountability at All Levels.
    2. Strengthen Workforce Experience and Wellbeing.
    3. Deliver Equitable, Culturally Competent Services.
    4. Empower Communities and Partnerships.
    5. Use Data and Evidence to Drive Improvement.
    6. Learn, Reflect and Share.

The following points were made in discussion:
(i) Board Members welcomed the Plan and the development through collaboration.
(ii) Following a question on next steps, it was noted that getting the membership of the working group right would be crucial. There needed to be wide representation.
(iii) There was a question on the governance reporting timescale. The Executive Lead and Chair of the Staff Governance Committee would consider the frequency of reporting to the Committee. The work associated with the Plan would keep going in order to move forward actions and deliverables as soon as possible.
(iv) Members asked how the Plan fitted with the rest of the corporate plans and their actions and deliverables. It was noted that protected characteristics linked to all areas of work and the Plan aligned with the Population Health & Care Strategy as well as other relevant strategies. The Programme of Work drew together actions from disparate plans in one place. There had been a mapping of local and national plans so the Executive were clear where each action sat and which Programme Board was responsible.
(v) The Anti-Racism Plan was one of the organisation's equality outcomes. The EQIA had pulled out the theme of intersectionality. Mitigations would be enhanced as work progressed.
(vi) A question was asked on data collection relating to inequalities. Public Health Scotland had training on this and information allowed insight into who was attending and not attending services.
(vii) Members noted that the Staff Governance Committee had a key role in monitoring the Plan but that the focus there would be on workforce whereas the plan had a wider focus on the population. The Healthcare Inequality Action Plan would thread through all services and there would be some reporting to the Clinical Governance Committee. The governance routes for different elements would be considered as the Board needed assurance and clarity on all aspects with clear measurable indicators.
(viii) Following a point on wider public sector linkages and the role of Anchor organisations, it was noted that the working group had considered Anchor involvement. Another key group were the Community Planning Partnerships. In relation to misinformation, there had previously been joint messaging from the Forth Valley Community Planning Partnerships on community cohesion, tackling racism and supporting those who faced racism.
(ix) There was a question on the detail of risk mitigations in the appendices to the report. Further information would be provided outwith the meeting to clarify the mitigations.
(x) It was raised that it was reassuring to hear detail on the joint working. As primary care barriers could be significant it was suggested that it would be important to tie into the work being taken forward by the Health and Social Care Partnerships.

(xi) Members discussed that the Communications Plan needed to be underpinned by training and development to support this and how staff could take advantage of the opportunities available. It was noted that the Head of Organisational Development was on the working group and progressing work to train the trainers. There would also be work to ensure staff were comfortable in terms of data collections. A key data point was the uptake of training, both through TURAS and local provision. This data was then correlated against IR1s related to discrimination. This had been discussed at the working group and service meetings.

(xii) Member suggested that a quick win could be to ensure the Anti-Racism Plan was included at staff induction with a message encouraging uptake of learning opportunities.

(xiii) Adewale, Vice Chair of the Ethnic Diversity Network, commended the plan to the Board, highlighting the positive collaborative work which had taken place and the confidence this gave to implementing actions.

The Forth Valley NHS Board:

(1) approved the NHS Forth Valley Anti-Racism Plan as attached to the report;

(2) approved the Communications Strategy subject to revisions to be explicit on training and development opportunities;

(3) noted that the Staff Governance Committee would oversee reporting but recognised that other Committees had a role in this too;

(4) noted that the EQIA had been considered and taken cognisance of in decision making, and

(5) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action

(i) The Staff Governance Committee to consider monitoring against the governance structure. Kevin Reith

(ii) Ensure the Plan is included as part of employee induction. Kevin Reith

(iii) Revise the Communications Plan to be explicit on training and development opportunities. Kevin Reith

9. Robotic Assisted Surgery in NHS Forth Valley

The Forth Valley NHS Board considered a report for approval, presented by Mr Murray which provided the Business Case in relation to Robotic Assisted Surgery in NHS Forth Valley.This had previously been commented on by Board members.

The key messages in the report included:

(i) NHS Forth Valley provided complex cancer surgery in Colorectal, Gynaecology and Urology using traditional laparoscopic surgery. Robotic Assisted Surgery (RAS), offered an enhanced view, access and precision, resulting in improved patient outcomes.

(ii) The articulated instruments were held by the robot but controlled by the surgeon from the adjacent console. This removed unintentional human tremor, improved fluidity of movement, resulting in reduced operative time and complications. These advances demonstrate improved outcomes for patients, resulting in less morbidity, reduced post-op pain, shorter length of stay and a faster return to baseline function.

(iii) RAS generates cost avoidance by reducing complications, thus hastening recovery and freeing up bed days. It was estimated that the annual cost

avoidance for NHS FV would be £0.5m per year, with 605 days released once fully operational.

(iv) In June 2025, the UK Government committed to increase access to RAS to >90% by 2035, versus 20% currently.

(v) Four options were set out in the report. Option 1 described the status quo where colorectal patients had no access to RAS. Option 2 was to send Forth Valley patients to other centres for surgery but there was currently no capacity to do this. Option 3 was to send Forth Valley surgeons and patients to other centres to perform RAS but again was limited by capacity and cost. Option 4 was to purchase a robotic system and was recommended.

(vi) Capital costs were estimated at £2.6m to purchase the robot and carry out the necessary local decontamination upgrades. The Scottish Government had confirmed that they would provide an additional £2.5m in capital funding through the National Infrastructure Board. The balance of £0.1m would be funded through local capital formula allocation.

(vii) Net additional recurring revenue costs had been quantified at approx. £0.6m p/a. Additional non-recurring revenue funding of £0.5m had been confirmed from Scottish Government to meet running costs in the first year of operation (2026/27). Future year revenue costs from 2027/28 had been included in the NHS Board Financial Plan.

The following points were made in discussion:

(i) There had been an opportunities for Board Members to discuss the proposal, shape and influence it and receive assurances via the Strategic Planning, Performance & Resources Committee, Board Seminar and e-mail comments to ensure the Business Case covered assurances required.

(ii) There was a question on where training would be provided and what the costs were. In order to deliver the anticipated patient benefit training was vital. The training centre was at the Golden Jubilee, appropriate lead-in time for training had been factored in.

(iii) Discussion took place on how financial benefits would be measured and tracked. The report set out detailed information in relation to the additional costs which would be incurred and cost reductions through efficiencies. Monitoring would be through the fortnightly Financial Stewardship Board. There would be further oversight as the Chief Executive and Director of Finance held meetings with management teams and there were the quarterly Directorate performance reviews. As other Boards already had Robotic Assisted Surgery arrangements in place there would be learning from their experiences.

(iv) Members commented on the complications from laparoscopic surgery and noted that procedures conducted with robotic assistance were better outcomes for patients.

(v) A question was raised about the reduction of one band 3 position in the business case with a view that such decisions were not for the Board to take. The reference to staffing levels would be removed from the Business Case if approved by Board.

(vi) Members asked about succession planning and the number of surgeons accessing the robot. There was a balance to strike in order to ensure that the benefits were delivered to patients, surgeons required a critical mass of use to maintain their skills. Access would therefore not be widened too much in the early stages.

(vii) Members discussed the evolving nature of medical technology and what future scanning was done to look at a programme of capital upgrades and identify any gaps. The purchase of the robot, with different teams using it, should meet current needs. There needed to be the right level of activity to get the right

outcomes. Given the experience of other Boards, the local team knew how to best utilise and get value from this. Although technology was ever evolving, this would deliver the best for patients now.

(viii) A question was asked on the re-use of the kit which would no longer be required and whether it could be sold. There were routes for disposal, and the best use would be considered through the decommissioning group. Detail on the re-provisioning would be provided when available.

The Forth Valley NHS Board:

(1) noted that Board members had had a number of opportunities to provide feedback and influence in shaping the Robotic Assisted Surgery proposal detailed in the Route to the Meeting to ensure that appropriate assurance had been provided;

(2) noted the associated financial implications in terms of anticipated capital and revenue costs and funding sources;

(3) approved the acquisition of a Robotic Assisted Surgery (RAS) system as set out in the Business Case subject to removal of the content relating to staffing implications, and

(4) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Actions

(i) Provide information to Board Members on the re-provisioning of any kit no longer required once determined by the Decommissioning Group. Andrew Murray

10. Corporate Objectives 2025/26 Progress Update

The Forth Valley NHS Board considered a report for assurance, presented by Professor McGuffie, which provided an in-year update on progress made in the delivery of the Corporate Objectives 2025/26 through the Programme Board structure.

Key messages in the report included:

(i) 2025/26 was the first full cycle of NHS Forth Valley's Programme of Work methodology. This approach was designed to strengthen organisational delivery by:

- Establishing a streamlined suite of Corporate Objectives.
- Agreeing clear annual deliverables under each objective.
- Setting Executive Objectives to ensure accountability for strategic leadership.
- Implementing a structured governance model through Executive-chaired Programme Boards.

(ii) A system-wide review session with the Senior Leadership Team in November assessed performance, identified areas on track, and highlighted where additional support was required. A key learning point was the need to bring next year's SLT review forward to October, enabling earlier visibility of risks to delivery and allowing for more timely escalation to the Board or SPPRC.

(iii) Overall, the Programme of Work approach was driving improved transparency, shared ownership, and cross-organisational collaboration. Progress against each Programme Board portfolio was summarised in the report.

The following points were made in discussion:

(i) Discussion took place on how to reduce overlaps and the best way to streamline reporting to Board. It would be important to have single reporting rather than duplicate or pull in additional material for Board. The chapters of the Population Health & Care Strategy had been broken down into Programme Board alignment.

(ii) Board Members sought to ensure that there was sufficient reference to the Population Health & Care Strategy, which as the organisation's key 10 year plan should be front and centre. The mapping piece of work was massive. The Programme Boards led on delivery of the Strategy and then reported to SLT.

(iii) Members asked that risk reporting was standardised and whether current escalations were appropriate. There would be standardisation as much as possible across the Programme Boards. In terms of risks, the Board asked for assurance on what was met and what not. Reporting should identify where matters were offtrack with linkages back to corporate risks. There would be twice yearly reporting built into the schedule going forward.

(iv) A question was asked on when there would be further updates provided. Reporting would be aligned to the Board and Remuneration Committee schedules. There would be a further report on 2025/26 beyond year-end. It was asked that in future reports there was information to show alignment to Governance Committees.

The Forth Valley NHS Board:

(1) noted the progress made in the delivery of the Corporate Objectives 2025/26;

(2) requested a further update reflecting the year end position and lessons learned noting biannual progress reports would be scheduled in 2026/27, and

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Actions

(i) Programme in twice yearly updates in Board Schedule of Business. Jack Frawley.

(ii) Date for next report to be confirmed. Kerry Mackenzie/Jack Frawley.

The Board adjourned at 11.25am and reconvened at 11.45am with all members present as per the attendance list.

Quality & Safety

11. HIS Unannounced Mental Health Services Safe Delivery of Care Inspection - NHS Forth Valley

The Forth Valley NHS Board considered a report for assurance, presented by Professor Goudie, which provided an overview of the published HIS Safe Delivery of Care Inspection report of Mental Health Services at NHS Forth Valley.

Key messages in the report and presentation included:

(i) HIS conducted an unannounced Safe Delivery of Care inspection of Mental Health Services at Forth Valley Royal Hospital, with the observational component of the inspection taking place between 25 and 26 August 2025.

(ii) During the inspection HIS inspected the ward and hospital environment; observed staff practice and interactions with patients, such as during patient mealtimes; spoke with patients, visitors and ward staff; accessed patients' health records, monitoring reports, policies and procedures.

(iii) The HIS report was published on 28 January 2026 and identified:
- areas of good practice
- 1 recommendation
- 19 requirements

(iv) A joint action plan had been agreed to address the associated recommendations and requirements. A local action plan had also been developed to ensure that the recommendations and requirements were being addressed accordingly. A summary of progress with this was provided as an appendix to the report.

The following points were made in discussion:

(i) Members noted that the inspection found that staff treated patients with care and compassion but recognised the need to make improvements.

(ii) Following a question, it was confirmed that the oversight group considered themed analysis across inspections to ensure shared learning was considered.

(iii) Member sought further information and assurance on the compliance with mandatory training and PDP. This had improved since the Inspection. In terms of PDP how rotas were built was being looked at to ensure that there was time for release. OD were leading on work to increase PDP compliance. There was now a full day a week of protected time for senior charge nurses to deliver key management actions. There was 65% compliance with violence and aggression training in mental health with process issues against progress. 95% compliance was the right aspiration with the oversight group tracking progress.

(iv) The Board noted the detail of the action plan and the need to deliver improvements at pace.

(v) There were questions on likely follow-up inspections. It was likely that there would be further inspection activity, however local governance arrangements were in place to monitor improvements regardless of who visited. Further visits would be welcomed as services were proud of the progress made to date.

(vi) Questions were asked as to whether appropriate escalation processes were in place and whether estates defects and related issues were known about prior to the inspection taking place. The specific issues around water outlet, en-suite environment and roof space were known and action being taken on.

(vii) Following a question on falls and pressure ulcers, it was noted that process reliability of risk assessment needed to be improved.

(viii) Board members stated that further assurance was needed that the clinical governance system at the frontline worked effectively. There was an established quality management system in NMAHP which included supportive visits. Care reliability was fed back to the safety steering group and would be tied to the Quality Seminar discussions

(ix) Members sought clarity on the follow through of governance around actions 8 and 19 relating to sexual safety and privacy. The Sexual Safety Policy would be submitted to a future meeting of the Clinical Governance Committee. Development of the policy was underway prior to the inspection, and it would apply system wide. There was commitment to a review for mental health services in terms of placements.

The Forth Valley NHS Board:

(1) noted the findings of the HIS Inspection and the associated risks;
(2) noted the proposed Action Plan addressing HIS recommendations;
(3) was assured that the correct actions were in place and being progressed as per timescales with oversight through the Clinical Governance Committee, and
(4) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Actions
(i) Staff Governance Committee to consider whether strengthened scrutiny of mandatory training and PDP compliance was required, particularly in relation to the availability of trainers. Kevin Reith
(ii) Clinical Governance Committee to consider any gaps in relation to reporting and the continuous improvement lens on internal assurance processes. Karen Goudie.

12. Spotlight on Services – Ward Product Management, Forth Valley Royal Hospital
The Forth Valley NHS Board considered a report for assurance, presented by Mr Urquhart, which provided an overview of the Ward Product Management service.

The Board had the benefit of a video story item in relation to the service introduced by Mr David Logie, Head of Procurement.

Key messages in the report included:
(i) The Ward Product Management Service directly supported clinical care, delivered significant cost savings, and aligned with the principles of Value Based Health and Care. The service consistently improved efficiency, reduced waste, and freed nursing time to focus on patients.
(ii) NHS Forth Valley was one of only a few boards which offered a level 1 service and held a ten-day supply of stock. The Ward Product Manager role provided all aspects of stock management for each ward/department.

The following points were made in discussion:
(i) The Board thanked the team for their hard work and contributions to the quality of care delivered to patients. The importance of waste avoidance work was noted which allowed the organisation to only carried the stock it needed.
(ii) Following discussion, it was noted that the Medical Director would work with the service in relation to identification of clinical leads.
(iii) Board members highlighted the high degree to which the Board valued the service.
(iv) It was noted that many staff had been in the service for long periods which was seen as a reflection of positive culture. A question was asked on how far the service could reach into communities and primary care. There were linkages for the team to Therapeutics, further opportunities were always welcomed and explored.
(v) The Board's Climate Change & Sustainability Champion highlighted that if progress could be made with HSCPs to develop opportunities to reduce waste this would have a positive impact on carbon footprint.
(vi) Members asked how the knowledge required to undertake the role of WPM was passed on when there was staff turnover. When there were new starts into the team it generally took around 6 months to fully get to grips with the systems element and build the experience knowledge of what wards needed in terms of products.

(vii) The Board Chair noted that the team displayed leadership, good culture and stewardship. She would write to the team on the Board's behalf to note their thanks.

The Forth Valley NHS Board:

(1) recognised the significant value and positive impact the Ward Product Management Service had on the day-to-day management of services and departments across NHS Forth Valley;

(2) noted that key Clinical Leads for the introduction of any new National Contracts will be identified, enabling product evaluations to be undertaken in advance of board-wide implementation, and

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

13. Finance Report

The Forth Valley NHS Board considered a report for assurance, presented by Mr Urquhart, which provided an overview of the month 10 financial results and an updated forecast outturn for the year.

Key messages in the report included:

(i) The 2025/26 year-end outturn projection remained a break-even outturn against revenue and capital resource limits at 31 March 2026, subject to final risk areas.

(ii) Further work had progressed in relation to quantification of expected IJB risk sharing requirements for 2025/26 and on confirmation of outstanding funding allocations.

(iii) The draft three-year financial plan had been submitted to Scottish Government in early February, with key points having been considered at the Board Seminar. A revised plan would be considered by the Board for approval on 31 March 2026.

(iv) A Quarter 3 financial review meeting had been held with Scottish Government on 13 February to review the in-year financial position, assess progress on delivery of savings plans, and to discuss initial feedback on draft financial plans for 2026/27.

(v) Initial discussions on sub-national financial plans were taking place with Scotland West Boards to identify initial priority areas for review and opportunities for improvement. Further updates would be provided through the Strategic Planning, Performance and Resources Committee as this area of work developed and progressed.

The following points were made in discussion:

(i) While the projected year-end position was breakeven, continued care needed to be taken to deliver that result.

(ii) The draft financial plan would be considered at the Board Seminar on 3 March.

The Forth Valley NHS Board:

(1) noted that a break-even position against both revenue and capital sources was projected for 2025/26 subject to identified risks in the last 2 months of the year;

(2) noted the ongoing work in relation to financial planning in advance of final plan submission, and

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

14. Performance Report

The Forth Valley NHS Board considered a report for assurance, presented by Ms Mackenzie which provided an update on performance against a range of national and local measures.

Key messages in the report included:

(i) Performance Summary.
(ii) Area of Focus – Urgent & Unscheduled Care.
(iii) Performance Report: Priority Areas of Performance.
(iv) Performance Scorecard.

The following points were made in discussion:

(i) Board members noted that there was slight increase in readmission and asked if any work was needed in this area. The Acute team monitored readmission rates every two weeks. They were assured that there was no issue to be concerned with. If the rate continued to rise there would be further consideration of this.
(ii) A question was asked on when screening programme data would be available and where it reported. Screening data would be included in the public health report to the Clinical Governance Committee which would be shared with Board members.
(iii) There was a question on whether occupancy pressures had only been seasonal through January. The occupancy rate was down significantly. January and February were the busiest time of the year but there was nothing problematic. Planned Care ran all winter with the exception of just one day which was excellent performance.
(iv) Board Members discussed the need for improvements in the 4 hour performance target and the impact on performance against the 12 week treatment time guarantee which would be seen as the amount of mutual aid increased taking long waiting patients from other Boards. It was acknowledged by Members that performance would continue to worsen against this 12 week measure due to the impact of treating long waiting patients from elsewhere.
(v) With reference to contingency beds a £1.9m spend for this year was noted, clarity was sought on whether this was seasonal and how it would be monitored in reports. There was weekly service reporting on contingency beds. The number of contingency beds was 30 to 40 lower than the peak in the previous year. HSCP work on flow had helped to reduce the number. In December the number of beds open had been nearly zero but this had increased through the seasonal pressure.

The Forth Valley NHS Board:

(1) considered the latest performance data within the Performance Report and noted the Area of Focus – Urgent & Unscheduled Care and Priority Areas of Performance;
(2) considered the progress made in reducing the number of patients waiting over 52 weeks for a new inpatient appointment and for an inpatient/daycase procedure, and
(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Actions

(i) Circulate the Public Health report submitted to a future Clinical Governance Committee with Board Members. Jack Frawley.

(ii) A progress report on the Emergency Department 12 Week Improvement Plan to be submitted to the Strategic Planning, Performance & Resources Committee. Garry Fraser.

15. Schedule of Business

The Forth Valley NHS Board **noted** for information the Schedule of Business.

16. Any Other Competent Business

A matter was raised in relation to the UK losing the Measles Elimination Status. Scotland wide and that to have herd immunity there required to be a 95% vaccine uptake level, actual uptake was around 91% to 92%. Work would continue to target increases in uptake.

Valedictory – Employee Director

The Board Chair led the Board in expressing thanks to Robert Clark who was retiring from the post of Employee Director. The Chair thanked Robert for his dedication and contribution over his many years of service and wished him well in the future.

17. Risks and Reflections

The Forth Valley NHS Board resolved that there were no matters to recommend that the Senior Leadership Team consider to be included in the Strategic Risk Register.

18. Date and Time of Next Meeting: Tuesday 28 April 2026 at 9.30am.

FORTH VALLEY NHS BOARD

3(b). Minute of the Forth Valley NHS Board Meeting held on Tuesday 31 March 2026
For: Ratification

Minute of the Forth Valley NHS Board Meeting held on Tuesday 31 March 2026 at 9.15am in the Boardroom, Carseview House.

Present:
Ms Neena Mahal (Board Chair)
Ms Kirstin Cassells (Non-Executive Director)
Cllr Fiona Collie (Non-Executive Director)
Cllr Scott Farmer (Non-Executive Director)
Professor Karen Goudie (Executive Nurse Director)
Ms Alison Jaap (Non-Executive Director)
Mr Gordon Johnston (Non-Executive Director)
Cllr Fiona Law (Non-Executive Director)
Professor Ross McGuffie (Chief Executive)
Professor Clare McKenzie (Non-Executive Director)
Ms Karren Morrison (Non-Executive Director)
Mr Allan Rennie (Vice Chair)
Mr Finlay Scott (Non-Executive Director)
Mr John Stuart (Non-Executive Director)

In Attendance:
Ms Jennifer Borthwick (Interim Chief Officer, Clackmannanshire & Stirling IJB)
Ms Elsbeth Campbell (Head of Communications)
Mr Tom Cowan (Head of Strategic Planning & Transformation, Falkirk IJB)
Ms Caroline Docherty (Head of Community Services, Falkirk IJB)
Mrs Morag Farquhar (Director of Facilities)
Mr Jack Frawley (Board Secretary)
Mr Scott Jaffray (Director of Digital)
Marie Kiers (Chief Finance Officer, Falkirk IJB)
Ms Kerry Mackenzie (Acting Director of Strategic Planning, Performance & Resources)
Ms Jackie McEwan (Corporate Business Manager)
Mr Kevin Reith (Director of People)
Ms Jillian Thomson (Deputy Director of Finance)

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1. Welcome, Apologies for Absence and Confirmation of Quorum
Apologies were intimated on behalf of Jennifer Champion, Stephen McAllister, Andrew Murray and Scott Urquhart. The Board meeting was quorate.

Laura Byrne, Garry Fraser and Gail Woodcock were not in attendance.

2. Declarations of Interest
There were no declarations of interest.

3. Draft Financial Plan
The Forth Valley NHS Board considered a report for decision, presented by Ms Thomson which provided the draft 3-year Financial Plan covering the period from 2026/27 to 2028/29. It was noted that Board members had discussed the Plan as it

had been developed through Board seminars on 10 February 2026 and 3 March 2026.

The key messages in the report included:

(i) The plan reflected feedback from the Scottish Government on an earlier draft submitted in February together with a number of changes in funding assumptions and costs which had been confirmed in the previous month. The plan also reflected the refreshed 15 box grid and associated actions issued by the Scottish Government on 27 February 2026.

(ii) Based on known and anticipated planning assumptions, the financial plan for 2026/27 forecast a break-even position. This was dependent on the delivery of £38m of savings.

(iii) Achieving savings on that scale would require sustained organisational focus and the continued application of rigorous financial controls, alongside detailed scrutiny of the in-year financial position.

(iv) For years two and three of the plan, there was a higher degree of uncertainty on future funding settlements, inflationary pressures, new and emerging cost drivers and the scale and timing of potential savings opportunities.

The following points were made in discussion:

(i) A question was asked on the financial implications of prisoner healthcare, noting that Forth Valley had a disproportionately high level of prisoner population. In previous years the Scottish Government had provided non-recurring funding to assist with the financial pressures arising from this. The matter was largely outwith local control. A business case had been submitted to secure funding on a recurring basis and discussion continued with the Scottish Government on this. The Chief Executive and Falkirk IJB Chief Officer were members of key national prison related groups and continued to highlight this issue in those forums.

(ii) Clarity was sought on whether requests for funding in relation to prisoner healthcare covered full costs, such as administration support recognising that there was a higher than average level of complaints received in this area. Discussions regarding resource did focus on the totality of need and was looked at in the round.

(iii) Members sought clarity on whether financial planning assumptions was based on there being no risk share in place for the IJBs. Some additional Scottish Government funding had been received at year-end with flexibility being sought to manage future year IJB financial pressure.

(iv) There were comments on the importance of Value Based Health and Care to the future of financial planning. As this may require challenging decisions it would be important to consider how issues or risks to delivery were overseen, particularly in relation to disinvestment in services. It would be important to have proactive Board discussion. At the recent Acute Directorate Performance Review there had been discussion of the next service areas which were keen to progress through transformation using the VBHC approach. When the Chief Medical Officer recently visited there had been discussion on VBHC. Hyperhidrosis and Lidocaine Patches had been nationally identified as areas of low clinical value which gave strong footing to take decisions on disinvestment.

(v) A question was asked on the impact of current and emerging geo-political matters on utility cost assumptions within the financial plan. In relation to inflation a 2% national planning assumption had been included but other models had been looked at as well including higher levels of inflation. Energy was procured nationally and there would be a careful watch on this situation.

Forth Valley had advanced purchased a signification amount of gas and electricity for the coming year which gave some resilience.

(vi) Members raised the issue of when higher than modelled inflation would be crystalised as a risk as any increase beyond the modelling would require additional savings. Members expressed that action should be taken sooner rather than later and that revised savings plans should be brought back to Board if material changes were needed.

(vii) Members noted that communication on the financial plan was important. How the Board engaged and worked with staff to enable them to contribute savings ideas would play a vital role. Although a break-even position was forecast for the next year that was only possible with delivery of significant savings~~,~~ Board members noted the hard work of staff to date to help deliver financial controls, but it was important to get the message out that there was still significant financial pressure on the organisation going forward.

The Forth Valley NHS Board:

(1) approved the 3-year financial plan, noting the key financial planning assumptions and estimates applied;

(2) noted the significant level of financial challenge identified and the associated risk to delivery of financial balance during the 3-year period;

(3) approve the proposed payments to IJBs for financial year 2026/27 which reflect the agreed uplift as advised by the Scottish Government, and

(4) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

4. NHS Forth Valley Corporate Objectives

The Forth Valley NHS Board considered a report for decision, presented by Professor McGuffie, which provided an updated proposal for the Corporate Objectives which would direct the agreement of specific 2026/27 organisational objectives which would be captured in the Delivery Plan and support progress against the Population Health & Care Strategy. It was noted that Board members had previously contributed to and influenced the shaping of objectives through discussion at SPPRC.

Key messages in the report included:

(i) The NHS Forth Valley Corporate Objectives reaffirmed ambition and purpose as an organisation, aligned with Scottish Government Guidance and provided a link between national and local context. The Board revisited its corporate objectives annually to provide direction for staff whilst promoting action towards goal-related activities and behaviours that aligned with values.

(ii) Staff would be supported when developing and agreeing their objectives and personal development plans to which they are held to account.

(iii) The Corporate Objectives were:

Collaboration: We will collaborate locally, sub-nationally and nationally to deliver shared priorities at pace, with clear accountability, aligned governance and demonstrable benefits for population health, service sustainability and workforce wellbeing.

Transformation: We will reform and redesign the way we deliver health and care services to meet current and future challenges, including demographic change, widening inequalities and improving the quality and safety of services.

Stewardship: We will strengthen stewardship capability and accountability at all levels to ensure that we have a positive and proactive approach to clinical, staff and financial governance across the organization.
Outcomes: Focus our services, funding and efforts on the areas which will achieve the greatest impact, benefits and outcomes to improve the health and wellbeing of our whole population.

The following points were made in discussion:

(i) There was discussion on the relationship between the Corporate Objectives and Personal Development Plans. Members asked about the value of this influence when PDP compliance was an area of required improvement. There were also comments on associated culture with consideration of sickness absence, motivation and return to work interviews. All Executives were targeting 80% sign off for PDPs in the coming year. The Corporate Objectives fed directly into the objective setting for Executives, and this then cascaded down through the organisation. The 2026/27 deliverables were split across the Executive Team who were then held to account for delivery.

(ii) In relation to the roll out of a human learning system, this had been considered by the Staff Governance Committee with it yet to be ascertained whether this was an appropriate and proportionate approach. The Human Learning System was a Healthcare Improvement Scotland approach which sought to create a culture which empowered frontline teams with learning feeding into the organisation. This should be a two way process. The system ensured that learning was cascaded and spread. This would help learning through VBHC to spread throughout the organisation.

(iii) Members noted that the version presented to Board was much clearer and improved from previous draft versions. There was a good narrative which was clear on what was trying to be achieved and appropriate for wider dissemination throughout the organisation. There were comments on ensuring the role and value of risk management was held alongside the objectives.

The Forth Valley NHS Board:

(1) approved the proposed Corporate Objectives refresh as a frame for delivery aims during 2026/27, and

(2) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

5. Whole System Urgent and Unscheduled Care Plan

The Forth Valley NHS Board considered a report for decision, presented by Professor McGuffie and Ms Docherty, which provided an overview of the developing Forth Valley Whole System Urgent and Unscheduled Care Plan and sought approval of continued funding for 2026/27 for Shifting the Balance of Care – Delayed Discharges.

Key messages in the report included:

(i) The intention to build the Shifting the Balance of Care approach into a business as usual element of whole system working across both health and social care partnerships during the course of 2026/27, with ongoing financial implications being brought forward to NHS Board in due course as part of the overall urgent and unscheduled care programme of investment.

(ii) The 2025 test of change, Shifting the Balance of Care through Discharge to Assess, contributed to significant improvements, including sustained reductions in delayed discharges, improved patient flow, fewer bed days lost for older people, and a meaningful shift toward enabling people to remain at home rather than move directly into long-term care. The model aligned with national and local priorities to deliver care closer to home and reduce harm associated with prolonged hospital stays

(iii) The UUSC plan sought to maximise the opportunity for whole system financial sustainability, by providing the right care, at the right time and in the right place to reduce deconditioning and other potential harms as a result of longer hospital stays than required. The whole system approach would also support market facilitation in the community, helping with financial stewardship as well as protecting valuable community resource for those with greatest need.

The following points were made in discussion:

(i) Members requested that there were metrics provided in relation to the impact on hospital flow and use of 5 bedded bays when being asked to take a longer-term funding decision in the future. Additional flow metrics would be considered. The use of contingency beds had been reduced from around 120 beds to 30. There had been a significant improvement, but performance was still not where it needed to be. Patient and workforce experience measures would also be considered. In terms of Hospital at Home there would be a look at how to maximise this model. The approach would continue to build up as part of the preventative focus of the Board. The Frailty Unit was increasing its operation to 7 days a week and the Community Frailty Model was being looked at.

(ii) There was discussion on the Equality Impact Assessment and the service provided to people whose homes were not suitable for discharge or required adaptation. A health home was required to enable recovery. A holistic view would be taken. The service had considered a Dutch Model which looked beyond just keeping people in their homes but rather on aspiring to a high quality of life. Community connections were important alongside other factors including family and poverty and this whole area was under consideration by the Partnerships.

(iii) A question was asked on why Criteria to Reside operated on a 3 day a week basis and whether there was rationale for the service not running on more days. The service operated on 3 rather than 5 days as when launched in December the senior team was supporting winter site pressures and the Criteria to Reside approach was very resource heavy. Through the creation of a Integrated Discharge Team there was an aspiration to move to a 5 day service. It was important to get people home with the least deterioration possible.

(iv) Members asked whether there could be an economic impact assessment on this work and the move to more prevention and early intervention. There would be focus on how to create the most efficient model to deal with hospital demand. It was cheaper to support people at home with earlier discharge through the reduction of longer term packages of care, although there could be initial higher spend on intense packages to support discharge.

(v) There was discussion on the recent Scottish Parliament consideration of the Assisted Dying for Terminally Ill Adults (Scotland) Bill and related discussions on improvements to palliative care. There should be whole system support which delivered good quality palliative care. The review of the approach would be whole system and include partners such as Strathcarron Hospice and MacMillan. There was an aim to deliver consistent support.

(vi) A briefing note was requested on lessons learned from previous improvement actions and how they had been taken into account in recent proposal development. This should include a previous initiative to reduce bed capacity at Falkirk Community Hospital and increase community capacity.
(vii) Members requested that alongside financial impact that patient and workforce experience were also built into any future evaluation. Patient care measures were now part of Care Opinion, and this was being promoted across all service areas. Feedback would be secured directly from patients.
(viii) A question was asked on whether zero tolerance to breaches in the 12 week ED flow program was realistic given current performance. The zero tolerance to breaches was a medium term ambition but was a key metric in terms of patient harm.

The Forth Valley NHS Board:

(1) noted the developing Forth Valley Whole System Urgent and Unscheduled Care Plan, including seeking the fully developed and costed plan to come to a future board meeting;

(2) approved initial non-recurring transfer of £2,027,180 in 2026/27 from NHS Forth Valley to Falkirk Health and Social Care Partnership (HSCP) to maintain and embed the Discharge to Assess (D2A) / Shifting the Balance of Care model as a business-as-usual approach during 2026/27, noting that a further request to make the funding recurring from 2027/28 financial year onwards would come forward as part of the fully developed and costed UUSC plan;

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Actions

(i) Circulate a briefing note to Board Members on lessons learned from previous initiatives to shift care into the community. Ross McGuffie / Gail Woodcock

(ii) Capture future consideration of Shifting the Balance of Care in the Board workplan for 2026/27. Jack Frawley / Marie Kiers

(iii) Future papers on the topic to include information requested by Board including: effect on hospital flow; use of contingency beds; patient and workforce experience, and economic impact assessment. Gail Woodcock / Garry Fraser

6. Governance Report

(a) Clackmannanshire & Stirling IJB - Chair

The Forth Valley NHS Board considered a report for ratification, presented by Mr Frawley, which sought approval of Allan Rennie as Chair of the Clackmannanshire & Stirling Integration Joint Board.

Key messages in the report included:

(i) The Chair of Clackmannanshire & Stirling IJB moved to NHS Forth Valley Health Board from 1 April 2026.
(ii) Following distribution of a report to Board Members, electronic approval of the appointment was confirmed by 10 March 2026. The Board was asked to ratify that decision.
(iii) Allan Rennie currently served as Vice Chair of the IJB and his appointment would provide continuity and stability through a period of change within the IJB. It was

recognised that a further review of the NHS Forth Valley Board appointment may be required to take account of the completion of Allen's term of office as a Non-Executive Director of the NHS Forth Valley Health Board before the 2-year tenure was complete.

The Forth Valley NHS Board:

(1) ratified the decision to appoint Allan Rennie as the Chair of the Clackmannanshire & Stirling Integration Joint Board from 1 April 2026, and

(2) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

(b) Appointments Report

The Forth Valley NHS Board considered a report for decision, presented by Mr Frawley, which updated the Board and sought decision on the following matters:

(i) standing down of the Population Health & Care Task & Finish Group;
(ii) changes in Committee membership arising from the appointments of Cllr Scott Farmer and Karren Morrison as Board Members, and
(iii) appointment of a Counter Fraud Champion.

The following points were made in discussion:

(i) Members requested that where appointments were ex-officio, that they were marked as such in the reports to assist with the consideration of these matters.
(ii) There would be changes to full staff side membership of the Staff Governance Committee going forward.

The Forth Valley NHS Board:

(1) noted that the Population Health & Care Task & Finish Group had been stood down following publication of the Population Health & Care Strategy;

(2) noted that Cllr Scott Farmer had been nominated by Stirling Council and subsequently appointed by the Cabinet Secretary as the Stirling Council representative on the Forth Valley NHS Board;

(3) noted that Robert Clark retired from the role of Employee Director on 27 February 2026 and that Karren Morrison had been elected to the position of Employee Director. Her appointment as Employee Director and a Non-Executive Member was approved by the Cabinet Secretary from 2 March 2026;

(4) agreed to appoint Cllr Scott Farmer to the Audit & Risk Committee and noted his appointment to the Strategic Planning, Performance & Resources Committee;

(5) agreed to appoint Karren Morrison to the Audit & Risk and Remuneration Committees and noted her appointment to the Staff Governance and Strategic Planning, Performance & Resources Committees;

(6) agreed to appoint Karren Morrison as the Board's Counter Fraud Champion;

(7) noted that the Endowments Trustees agreed to appoint Finlay Scott to the Endowments Committee, and

(8) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

7. Any Other Competent Business
There was no other competent business.

8. Risks and Reflections
The Forth Valley NHS Board resolved that there were no matters to recommend that the Senior Leadership Team consider to be included in the Strategic Risk Register.

9. Date and Time of Next Meeting: Tuesday 28 April 2026 at 9.30am.

10. Business Taken in Private Session
The Board resolved in terms of section 5.22 of the Code of Corporate Governance, to consider the following item of business in private session on the ground that the Board was still in the process of developing proposals or its position on certain matters and needed time for private deliberation.

11. Draft Sub-National Plan 2026/27 – considered in private session.

4. Action Log
Forth Valley NHS Board – 28 April 2026

NO.	DATE OF MEETING	AGENDA TOPIC / ITEM	ACTION	LEAD	TIMESCALE	COMMENT / PROGRESS	STATUS
070	28.01.25	Integration Schemes	An update on any Ministerial feedback received.	Jillian Thomson / Ross McGuffie	25.08.26	The Falkirk Integration Scheme has now been approved by Scottish Ministers. The C&S Integration Scheme was approved by Board on 28 January and subsequently Stirling Council at its meeting on 6 February 2025. The dispute resolution process regarding the C&S Scheme is ongoing and making positive progress.	In progress
116	27.01.26	Strategic Risk Register Update: December 2025 – January 2026	Provide an update on the Primary Care Sustainability Board's work at the March SPPRC meeting.	Gail Woodcock	31.03.26	A report is being prepared for the March meeting of the SPPRC. The Primary Care Programme Board has now commenced. It is chaired jointly by the Chief Officer, Falkirk IJB and Depute Medical Director for Primary Care. The Terms of	Complete

NO.	DATE OF MEETING	AGENDA TOPIC / ITEM	ACTION	LEAD	TIMESCALE	COMMENT / PROGRESS	STATUS
						Reference include reference to the Board's and IJB's strategic risk on primary care sustainability. A report was provided to the 31 March SPPRC meeting.	
117	27.01.26	Quality and Assurance Report	Include consideration of performance reporting and a quality dashboard at the Board Seminar.	Andrew Murray / Karen Goudie	03.03.26	Consideration of this matter will be undertaken at the March Board Seminar.	Complete
119	27.01.26	Quality and Assurance Report	Provide further information to Board members on the action plan for SAERs, to include resourcing information and a revised trajectory timeline for dealing with the backlog.	Andrew Murray	05.05.26	Information will be provided to the Clinical Governance Committee and shared with Board Members.	In progress
120	24.02.26	Audit & Risk Committee – 23 January 2026	Consider the process of Committee Member engagement in development of the Internal Audit workplan.	Scott Urquhart / Fiona Collie	28.04.26	Jocelyn Lyall, Chief Internal Auditor, attended the SLT meeting on 13th April to present details of the Internal Audit Planning process for 2026/27. She confirmed that Audit and Risk Committee members would be consulted on the draft internal audit plan for views and suggestions on audit areas.	Complete

121	24.02.26	The Minute of the Falkirk Integration Joint Board – 5 December 2025	Circulate the link to the Health & Sport Committee debate on IJB Voting Rights Extension to Board Members.	Jack Frawley	28.04.26	The link was circulated.	Complete
122	24.02.26	Anti-Racism Plan and Communications Plan	The Staff Governance Committee to consider monitoring against the governance structure.	Kevin Reith	28.04.26	Monitoring arrangements built into Staff Governance Committee Workplan through Equality Outcomes reporting.	Complete
123	24.02.26	Anti-Racism Plan and Communications Plan	Ensure the Plan is part of employee induction.	Kevin Reith	28.04.26	The Plan will be referenced within our new Welcome Induction Event programme due to launch in 2026/27.	Complete
124	24.02.26	Anti-Racism Plan and Communications Plan	Revise the Communications Plan to be explicit on training and development opportunities.	Kevin Reith	28.04.26	The Communications Plan has been revised to reflect the training & development opportunities.	Complete
125	24.02.26	Robotic Assisted Surgery in NHS Forth Valley	Provide information to Board Members on the re-provisioning of any kit no longer required once determined by the Decommissioning Group.	Andrew Murray	28.04.26	There is no surgical kit that will be decommissioned as a result of the RAS. In general, any surplus surgical equipment is offered to the Global Citizenship team at Scottish Government.	Complete
126	24.02.26	Corporate Objectives 2025/26 Progress Update	Programme in twice yearly updates in Board Schedule of Business.	Jack Frawley	28.04.26	Updates have been programmed into the Board Schedule of Business as included on today's agenda.	Complete

127	24.02.26	Corporate Objectives 2025/26 Progress Update	Date for next report to be confirmed.	Kerry Mackenzie / Jack Frawley	28.04.26	The next reporting dates for the Corporate Objectives are as set out in the Schedule of Business 2026/27.	Complete
128	24.02.26	HIS Unannounced Mental Health Services Safe Delivery of Care Inspection - NHS Forth Valley	Staff Governance Committee to consider whether strengthened scrutiny of mandatory training and PDP compliance was required, particularly in relation to the availability of trainers.	Kevin Reith	14.07.26		In progress
129	24.02.26	HIS Unannounced Mental Health Services Safe Delivery of Care Inspection - NHS Forth Valley	Clinical Governance Committee to consider any gaps in relation to reporting and the continuous improvement lens on local processes.	Karen Goudie / Andrew Murray	07.07.26	The Medical Director and Executive Nurse Director are in discussions to develop a quality and safety dashboard which will report up to the Board and provide assurance across key local and national metrics. The thematics for Safer Together 2 are also being scoped to plan for continuous improvement in areas which require improvement support, which are also linked to the HIS reports.	In progress
130	24.02.26	Performance Report	Circulate the Public Health report submitted to a future Clinical Governance Committee with Board Members.	Jack Frawley	07.07.26	The report will be circulated to Board Members once available.	In progress

131	24.02.26	Performance Report	A progress report on the Emergency Department 12 Week Improvement Plan to be submitted to the Strategic Planning, Performance & Resources Committee.	Garry Fraser	26.05.26	A report is being prepared for the May meeting of SPPRC to provide an update on progress of the Emergency Department 12 Week Improvement Plan.	In progress
132	31.03.26	Whole System Urgent and Unscheduled Care Plan	Circulate a briefing note to Board Members on lessons learned from previous initiatives to shift care into the community.	Ross McGuffie / Gail Woodcock	26.05.26	Work going on to review previous bed closures in Falkirk Community Hospital and lessons learned.	In progress
133	31.03.26	Whole System Urgent and Unscheduled Care Plan	Future papers on the topic to include information requested by Board including: effect on hospital flow; use of contingency beds; patient and workforce experience, and economic impact assessment.	Gail Woodcock / Garry Fraser	25.08.26	Latest Board paper includes new UUSC data pack which will be further expanded to include metrics such as number of contingency beds in use and patient/workforce experience data.	In progress
134	31.03.26	Whole System Urgent and Unscheduled Care Plan	Capture future consideration of Shifting the Balance of Care in the Board workplan for 2026/27.	Jack Frawley / Marie Kiers	28.04.26	This item is included in the Schedule of Business included on today's agenda.	Complete

STATUS:
Overdue
In progress
Complete

FORTH VALLEY NHS BOARD
Tuesday 28 April 2026

5(b). Highlight Report on Board Seminars
For: Information

Executive Sponsor: Kerry Mackenzie, Acting Director of Strategic Planning & Performance
Author: Jack Frawley, Board Secretary

Executive Summary
Board Seminars are held bi-monthly and provide an opportunity for members to consider issues in detail, allowing for development of understanding of strategic issues. The format of the sessions usually consists of a presentation or briefing from Executive Directors and managers leading the area of work, or staff involved in the work, followed by discussion and questions from members or a workshop focused on areas for board development.

Board Seminars are not decision-making meetings. The Seminars can, however, assist the decision-making process through in-depth exploration and analysis of a particular issue which will at some point thereafter be the subject of a formal Board decision. These sessions also provide an opportunity for updates on ongoing key issues.

Recommendation
The Forth Valley NHS Board is asked to note the report for information.

Key Issues to be Considered
The Board Seminar on 3 March 2026 was held in person at Carseview House, Stirling and attendees included Board members and members from the Senior Leadership Team.

The Seminar covered two topics:

- Draft Financial Plan 2026/27 Update
- Quality

The Finance session covered:
- Context – Scotland-wide position
- Feedback – Scottish Government Quarter 3 Review
- Feedback – from the previous Board Seminar. Board members had an opportunity to discuss the financial position, assumptions behind the Plan and key risks, and influence what they wanted to see in the final plan
- Update – on sub-national direction for finance

The Quality session covered:
- Why does Quality matter, and what does it mean to you.
- An update of progress, gaps and risks within our current approach to Quality.
- Consensus on the proposed approach to Quality and its implementation pathway including the effective use of data to drive improvement.
- Discussion regarding quality and performance indicators/measures and reporting mechanisms.

NHS Forth Valley
Forth Valley NHS Board

6. Board Executive Report
Purpose: This report is for Noting

Executive Sponsor: Ross McGuffie, Chief Executive
Author: Ross McGuffie, Chief Executive

Executive Summary
This report provides an opportunity to deliver a regular wide update from the Board's Executive Team, covering celebrating success; general updates; inspection activity; visible leadership; and horizon scanning.

Action Required
The Forth Valley NHS Board is asked to:
(1) note the contents of the report.

Governance Route to the Meeting and Previous Board Consideration
This Board Executive Report is a standing item at Board meetings, providing an opportunity to update the Board on key issues.

Risk Assessment and Mitigation
No risk assessment has been undertaken on this update report.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty
Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial and Infrastructure Implications
There are no financial implications within this update report.

Workforce Implications
The report details a range of positive development for staff wellbeing, including celebrating success, staff engagement and visible senior leadership.

Quality / Patient Care Implications
This report outlines inspection activity currently underway within the Board but has no implications around quality of care.

Population Health & Care Strategy
This report will include regular updates on key successes and developments around the population health strategy implementation.

Climate Change / Sustainability Implications
There are no sustainability implications within this update report. .

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

Appendices
Appendix 1 – Main Report

Appendix 1

1. Celebrating Success

1.1 Celebrating success is an essential part of reinforcing positive outcomes, enhancing staff morale and strengthening commitment to our organisational values. Recognising the great achievements of our dedicated workforce helps foster a positive culture, encourage collaboration and remind both staff and Board Members of the great impact we have on the population of Forth Valley.

1.2 Since the last Board meeting, there have been a number of positive areas of success, including:

- The Haematology and Blood Transfusion Laboratory at Forth Valley Royal Hospital has achieved **UKAS Accreditation** for the very first time. This significant milestone reflects the hard work, professionalism and dedication of the entire team and highlights their ongoing commitment to continuous improvement and patient-centred care. Achieving accreditation required strengthening of quality systems, rigorous review of processes, and consistent demonstration of excellence across every stage of the testing pathway. UKAS Accreditation provides strong assurance to clinical colleagues, partners, and, most importantly, patients that the service delivers accurate, reliable, and high-quality results. It confirms that the department now fully meets the requirements of ISO 15189:2022, the international standard for quality and competence in medical laboratories.
- An innovative approach, first trialled in NHS Forth Valley, to provide dedicated support to patients with cancer throughout their treatment journey, is to be expanded across Scotland. The **Single Point of Contact (SPOC) service** aims to makes life easier for patients with cancer by providing easier access to clinical teams for information and advice about appointments, tests and results, as well as details of the clinical and non-clinical support available for them and their family. Cabinet Secretary for Health and Social Care, Neil Gray visited Forth Valley Royal Hospital on 12 March 2026 to meet with staff in the SPOC navigation team and talk to local patients who had benefited from the service.
- Our **Medical Physics Department** has been approved as a training centre by the Institute of Physics and Engineering in Medicine for the Clinical Technologist Training Scheme. This recognition enables the department to train staff to a nationally recognised standard, supporting the development of in-house expertise and providing robust evidence of competency for the department's quality management system. Recruitment of clinical technologists can be challenging, and becoming an approved training centre strengthens the department's ability to attract both new graduates and experienced professionals looking to progress their careers.
- Public Health Scotland's latest bulletin on **Blood Borne Virus (BBV) testing** among people on opioid substitute therapy again highlighted NHS Forth Valley as having the highest update in Scotland. BBV OST best performing Board in Scotland. A further 3% improvement in Q2 data in Forth Valley now highlights 56.3% uptake, with a new stretch aim set at 65% for the Board. The next highest Board in terms of uptake is sitting at

45%, highlighting the excellent and innovative approach being taken within Forth Valley.

- The new **Da Vinci XI dual-console robotic system** has been delivered to Forth Valley Royal Hospital and installed in theatre 3. This robot-assisted platform has the potential to significantly enhance the delivery of complex surgery across colorectal, gynaecology and urology services, including cancer care and represents an important step forward for patient outcomes, workforce sustainability and future surgical training. Huge thanks go to all the staff involved in the detailed planning for the new robot and to the teams involved in managing the delivery and installation. Surgical and theatre staff will now undertake detailed training over the next few months with the aim of operating on the first patients in Summer 2026.
- A new integrated cancer support service has been formally launched across Forth Valley, bringing together health, social care and third sector partners to provide people affected by cancer with coordinated emotional, practical and financial support. Funded by Macmillan Cancer Support and the Scottish Government, the **Improving the Cancer Journey** approach has now been fully embedded within the established **Macmillan One to One (Mac One)** service, creating a single, person-centred offer that complements clinical care by addressing non-clinical needs earlier and more effectively. This strengthened model supports people and families to navigate the cancer journey, improves connections between hospital and community services, and helps individuals live as well as possible with and beyond cancer. Neil Gray, Cabinet Secretary, attended the launch event held on 25th February at Stirling University.
- Neil Gray, Cabinet Secretary for Health and Social Care, wrote to the Board to congratulate on the progress around creating a **sustainable, low carbon health service**. It was noted that NHSFV has now switched its fleet over to electric cars and light commercial vehicles (137 vehicles in total) reducing fleet emissions by 39% and overall business travel emissions by 14%. It was noted that NHSFV's overall emissions fell by 7% between 2023/24 and 2024/25.

2. General Updates

2.1 Since the last Board meeting, there have been a number of developments of note:

- Following the successful recovery of **Freedom of Information (FOI)** performance over the last six months, bringing the Board out of its escalated position with the Information Commissioner, a **debrief session** was held at the Senior Leadership Team meeting held on 2nd March. Learning from the approach will now be utilised to support earlier identification of issues and recovery where performance has slipped. The methodology used for FOI is already making a strong impact within complaints handling.
- It has now been confirmed that the current Long Covid service will transition to a **Post-Acute Infection Syndromes (PAIS) service**. The existing service, which provides holistic one-to-one nursing, physiotherapy and psychology support, will expand to support people living with Long

Covid, ME/CFS, post-infectious Postural Orthostatic Tachycardia Syndrome (PoTS) and other related conditions. This change reflects the success of the Long Covid service to date, as well as the evolving understanding of post-infectious conditions. The updated service model aims to provide a more inclusive and consistent approach for people experiencing a range of post-infectious syndromes. The updated service model will take effect from 1 April 2026, ensuring a smooth transition and continuity of care for everyone currently receiving support.

- Ronan Ging, Chief Nurse for Acute Services, has recently taken on the role as NHS Forth Valley's **Armed Forces and Veterans Champion**. Alongside his NHS career, Ronan holds the rank of Squadron Leader in the Royal Air Force Reserve and was previously their Senior Nursing Officer for England before transferring to 612 Squadron at RAF Leuchars. The Armed Forces Covenant is a key commitment for NHS Scotland in recognising and addressing the unique health and wellbeing needs of the armed forces community (which includes veterans and direct family members). Specialist training is available to support healthcare professionals across primary and acute care through the Armed Forces and Veterans' Recognition Scheme.

3. Inspection Activity

3.1 Since the last Board meeting, there has been ongoing inspection activity:

- An expert group has published its final report following ten months of independent oversight into the implementation of Fatal Accident Inquiry (FAI) recommendations relating to deaths in custody. The **Ministerial Accountability Board (MAB)** was established following Sheriff Collins' FAI into the deaths of Katie Allan and William Lindsay (also known as William Brown) at HMP & YOI Polmont, and tasked with overseeing implementation of the Inquiry's recommendations. Chaired by Justice Secretary Angela Constance, the board comprised six independent members drawn from legal, academic, operational, public health and third sector backgrounds. Family members attended two MAB meetings, with their contributions directly informing the board's considerations. 39 of 43 recommendations demonstrated measurable progress, with all of the NHSFV actions completed with the exception of the final signing of a new Information Sharing Agreement with the Scottish Prison Service, which is in the final stages of sign off. Work is now underway to ensure this learning is spread across other Health Boards in Scotland, commencing with a session at the May meeting of the national Prisoner Healthcare Executive group.
- A **follow-up unannounced inspection** was undertaken by Healthcare Improvement Scotland on 16th and 17th March at the front door of Forth Valley Royal Hospital. Evidence submissions have been completed and the team will continue to work with the inspectorate through the inspection process. Board members will be kept appraised once we receive feedback on the findings.
- Oversight Boards from the recent **Maternity and Mental Health inspections** are now fully operational, overseeing implementation of the action plans formed in relation to the recommendations identified.

Progress updates are reported through the Clinical Governance Committee of the Board.

4. Visible Leadership

4.1 In line with the Board's culture programme, the Executive Team are programming regular walk rounds and visits to provide an opportunity for positive engagement with staff. This programme aims to make it easier for staff to raise concerns or ideas with senior staff, foster a culture of collaboration and allow leaders to set a positive example, demonstrating commitment to our organisational goals and values.

4.2 Visits include:

- McMillian Improving Cancer Journey launch event
- Sim Safety Club at the Simulation Centre, FVRH
- Visit to the Carers Voice Group in Falkirk
- Service visit to Theatres
- CMO visit to FVRH with the VBH&C team
- Interviewing staff for VBHC videos
- Leadership event on 2nd April
- Clinical shifts
- Faculty of Medical Leadership event
- 'Frontline Friday' in the Stroke Unit
- University Leadership Event
- Ward 3, Mental Health
- The Promise visit
- Ward A21
- Active Stirling service visit
- Elected Member briefing in Stirling around Suicide Prevention

5. National and Regional Developments

5.1 The Board Executive Team have a number of lead national and regional roles, with updates as follows:

- Jennifer Champion, Director of Public Health, led a development session for Board Chief Executives on becoming a Population Health Organisation, supported by the King's Fund.
- The Chief Executive, Louisa McGuire and Fiona Struthers presented on our approach to Value Based Health and Care at the national Senior Leadership Community event, providing a great opportunity to highlight the work undertaken within Speech and Language Therapy, Dietetics and the Weight Management Service.

6. Horizon Scanning

6.1 Moving forward, Board members can anticipate further updates around the following areas of activity:

- The first draft of the West of Scotland Subnational plan has been submitted to Scottish Government for review.

7.3. Minute of the Staff Governance Committee Meeting held on Tuesday 20 January 2026

Minute of the Staff Governance Committee Meeting held on Tuesday 20 January 2026 at 9.00am in the Boardroom, Carseview House and via MS Teams.

Present:
Mr Martin Fairbiarn (Committee Chair)
Mr Robert Clark (Non-Executive Director)
Mr Nicholas Hill (GMB Representative)
Ms Alison Jaap (Non-Executive Director)
Mr Gordon Johnston (Committee Chair)
Mrs Karen Morrison (Unison Representative)
Ms Janet Sneddon (Royal College of Midwives Representative)
Mr John Stuart (Non-Executive Director)

In Attendance:
Mr Michael Brown (Head of Workforce Resourcing)
Mrs Morag Farquhar (Director of Facilities)
Mr Jack Frawley (Board Secretary)
Prof Karen Goudie (Executive Nurse Director)
Mrs Aileen Love (Head of Occupational Health)
Mrs Jenny McCusker (Head of Organisational Development)
Mrs Linda McGovern (Deputy Director of Workforce)
Miss Becky Reid (Corporate Services Assistant/PA) Minute
Mr Kevin Reith (Director of People)
Mrs Linda Robertson (HR Service Manager – Staff Governance)
Mrs Jo Tolland (Program Director, Culture Change and Compassionate Leadership Program) (Item 11)
Mr Scott Urquhart (Director of Finance)
Miss Vicky Webb (Corporate Risk Manager)

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1. Welcome, Apologies for Absence and Confirmation of Quorum
The Chair welcomed all present to the meeting. Apologies were received from Prof Ross McGuffie and Ms Neena Mahal.

2. Declarations of Interest
There were no declarations of interest.

3. Draft Minute of Staff Governance Committee Meeting held on Tuesday 18 November 2025.
The note of the meeting held on Tuesday 18 November 2025 was approved as an accurate record.

4. Matters Arising from the Minute / Action Log
The action log was reviewed, and the completed actions were acknowledged. The following updates were provided:

- Action 22 – would remain in progress until clarity on the response was received.
- Action 38 – Would be marked as complete following the context of the paper shared at committee.
- Action 45 – Would be considered for completion once update had been provided at this meeting.

- An additional action had been highlighted from discussions of the November meeting requesting an update on the guaranteed interview approach to improve permanent employment.
- A further additional action was highlighted requesting the outcome of the consideration of spend to save options for employment.

5. Staff Governance Committee Workplan 2025/26

The Staff Governance Committee considered the 'Staff Governance Committee Workplan 2025/26' presented by Mrs Linda Robertson to provide an update on any amendments that have been made within the workplan since the previous iteration presented to the committee.

Key messages in the report included: -

(i) A number of items would now be presented at the March meeting of the committee which included:
   a. A People Strategy Update
   b. A Professional Assurance Framework Paper
   c. Protected Learning Time for Agenda for Change Staff
   d. An update on the implementation of the Once for Scotland Statuary Modules
   e. Staff Governance Action Plans by Directorate /HSCP

(ii) An additional Culture Change & compassionate Leadership Programme update would be shared in March to provide the committee with assurance on the programme closure and the move to business as usual.

The following points were raised in discussion: -

(i) Mr John Stuart recognised the cross linkage of the Professional Assurance Framework between this committee and the Clinical Governance Committee recognising the necessity for this to be considered in both areas.

The Staff Governance Committee: -

- **Approved the updates to the Committee Work Plan for 2025/26.**

5b. Draft Staff Governance Workplan 2026/27

The Staff Governance Committee received the 'Draft Staff Governance Committee Workplan 23026/27' presented by Mrs Linda Robertson to provide oversight of the initial draft of the scheduled workplan for the upcoming year.

Key messages in the report included:

(i) Clarifications of reporting schedules of some areas was yet to be concluded.

(ii) An amendment had been changed to the document to reflect that the Staff Wellbeing Strategic framework would now be reported once in the reporting period.

(iii) The finalised draft of the 2026/27 committee workplan would be shared at the March meeting of the committee.

The following points were raised in discussion:

(i) Consideration of reporting period of the People Strategy was yet to be finalised recognising that this was due for approval in September, so the committee required more than one opportunity to discuss this item.

(ii) The Reduced Working Week (RWW) was scheduled for May following the implementation in April 2026. Recognised was that due to some areas were requesting a derogation due to patient safety and this would require to be closely monitored. The appropriate reporting method of the RWW would be clarified at the March meet of the committee.

(iii) Additional actions that were included within the Employability framework were to be added to the action plan as the next scheduled update was not until November 2027 and the committee requested an earlier update on these specific items.

(iv) The finalised draft of the 2026/27 Workplan would clarify whether the Employability Framework would be embedded within the Workforce Planning Updates going forward.

The staff Governance Committee:

- **Noted the draft 2026/27 workplan and provided comments as requested.**

Action:

- **Actions outlined within the minute of the Employability Framework from the September 2025 meet to be added to action log (with respect to guaranteed interviews and spend-to-save options).**
- **Address in the next version the comments made by the Committee (i.e. Committee involvement in reviewing the draft People Strategy; and Committee oversight of Reduced Working Week)**

6. Staff Governance Report – Including Workforce Performance Reporting

The Staff Governance Committee received the 'Staff Governance Report – Including Workforce Performance Reporting' presented by Mr Kevin Reith to provide the committee with an update on a range of Staff Governance and Partnership priorities, related workforce reporting metrics and associated improvement activity being undertaken to support enhanced performance and to mitigate present risks.

Key messages in the report included: -

(i) Sickness absence rates were still noted to be higher than desirable at around 8.6% in December, seasonal winter illness had impacted absences rate significantly and earlier than anticipated. Additional information had been included within the report on the work being implemented to reduce these figures with the aim of providing the committee with assurance.

(ii) Spend to save opportunities were being explored as part of the financial stewardship piece of work. As a spend to save opportunity 2 posts to support the HR team had been approved, a band 5 to solely focus on attendance management and support the team in collating this data, and a band 2 modern apprentice to provide admin support.

(iii) The Attendance Management oversight group had completed a comprehensive review of the approach to managing high absence rates. The initial action plan was included within the paper for awareness which would be refined as work progresses to include timelines where possible.

(iv) Employee relation cases saw an increase in grievance and conduct cases, whilst bullying and harassment cases declined. Long term cases continued to be escalated to the HR team to allow work to be carried out to remove these from the system.

(v) NHS Forth Valley remain out with the 80% KPI for PDPR completion at around 42.3%. Work would continue into next year towards achieving the anticipated KPI. Improving compliance rates would be done on a 2 phased approach, the first being to work proactively with the teams who want to continue improving and the second being taking a targeted approach to focus on the areas with low compliance to understand the necessary requirement to make beneficial improvements.

(vi) Additional charted information had been included within the report regarding recruitment and resourcing issues, but feedback was welcomed on how the committee would like to see this detail refined.

(vii) Work was underway within the Occupational Health team to mitigate wait times. Management referrals averaged around 9 days and there continued to be a focus on

the delivering of management referral training. Focus work was being carried out within psychological therapies as their waitlist remained high at 51 weeks due to capacity and demand issues.

The following points were raised in discussion: -

(i) SLT agreed to resource a senior nurse for a 6-month period solely dedicated to the oversight and governance of nursing absence due the majority of total hours lost being within this department. This was an additional post to the earlier mentioned band 5 and modern apprentice to ensure dedicated support to reducing absence figures.

(ii) Practice development had advised all NMHAP managers of the requirement of good PDPR compliance before clinical supervision could be rolled out in their area.

(iii) Comments were raised on the possibility of creating a timeline outlining the anticipated trajectory of the 2 phased approach to improving PDPR compliance. Whilst also recognising the need of the finer detail on the outcomes and impact of the action plan to improve attendance management.

(iv) Confirmation was provided that return to work interviews can be measured through the pentana system for reviewing at service performance reviews.

(v) Managers awareness and knowledge of the resources in place to support staff going through anxiety, stress or depression could be improved for managers through the work of the wellbeing framework. The induction programme for managers was being rebuilt to include this information.

(vi) Noted was that the senior charge nurse coming in to post for 6 months would have the capacity to investigate the management and wellness within the team and how these aspects are reported to ensure efforts to improve absence were being carried out in the appropriate areas.

(vii) The report outlined an increase in grievance cases but does not reflect the underpinning cause and it was agreed that this could be investigated further for feedback.

(viii) Although it was positive to see improvements within the timeframe of employee relation cases it would be valuable to understand the average length of time cases were taken to be concluded to determine what could be done to improve this.

(ix) A request was made for detail to be provided on the process in place if the expected timescales to conclude a bullying and harassment case extend passed the anticipated completion.

The Staff Governance Committee: -

- **Was assured on the process and procedures in place outlined within the Staff Governance Report except for Absence Management and PDPR compliance.**
- **Recognised the level of detail that had been included within the absence management section as requested but would like to see the anticipated timeline of improvement.**
- **Supported the targeted approach being taken within phase two of increasing PDPR compliance.**
- **Requested the anticipated timeline for improvement of the PDPR work be shared at the next meeting.**

Actions:

- **Underpinning cause of the increase in grievance cases to be shared.**
- **Detail of the average length of time to conclude an employee relations case to be included within the report.**

- **Outline the processes in place should a grievance case not be concluded within the anticipated timeframe.**

7. Staff Governance Terms of Reference

The Staff Governance Committee received the 'Staff Governance Terms of Reference' presented by Mr Kevin Reith to allow the committee to have oversight and provide feedback prior to onward submission to the NHS Board.

The Terms of Reference (ToR) was shared with committee members as part of the corporate governance cycle and there were no amendments to note.

The following messages were raised in discussion: -

(i) A query was raised on the context of paragraph 1.1 on the purpose of the committee recognising that the referencing to culture should be expanded to clearly define the stewardship of culture across the organisation as a whole and not only relative to staff management. Consideration would be given to this wording and circulated electronically to committee members for approval.

(ii) The wording of paragraph 2.2 was to be amended to reflect that whistleblowing was no longer in the introduction phase.

(iii) Committee members agreed their content for the ToR to be circulated electronically for approval for onward submission to the Forth Valley NHS Board for final sign off.

(iv) Following a query on the Employee Director being listed as an ex-officio member, it was clarified that the individual in post is a full member of the committee and their attendance was mandatory, in the same way as any other member.

The Staff Governance Committee: -

- **Was content with the ToR subject to the above points in discussion being rectified.**

Action:

- **ToR to be circulated electronically to committee members following the reviewing of the wording to the above stated paragraphs.**

8. Remuneration Committee Terms of Reference

The Staff Governance Committee received the 'Remuneration Committee Terms of Reference' presented by Mr Kevin Reith in line with the corporate governance review cycle.

Key messages in the report included: -

(i) The wording of paragraph 2.1.6 had been reworded to reflect wording to align with the core provisions for Remuneration Committee as outlined in MEL(1994)80, modified by MEL(2000)25.

(ii) Work was underway nationally to produce a model template for Boards to use for their Remuneration Committee which would be reflected once this had been received.

The Staff Governance Committee: -

- **Approved the Remuneration Committee Terms of Reference.**

9. Remuneration Committee Update

The Staff Governance Committee received the 'Remuneration Committee Update' presented by Mr Kevin Reith to provide oversight of the work undertaken by the Remuneration Committee in the performance year to date.

Key messages in the report included: -

(i) The Remuneration Committee Update was shared with the committee as standard practice.

(ii) The scheduling of the reporting of the Remuneration Committee updates was yet to be finalised.

The Staff Governance Committee: -

- **Was assured on the operation of the Remuneration Committee.**

10. Internal Audit Action update

The Staff Governance Committee received the 'Internal Audit Action update' presented by Mrs Linda Robertson to reflect on the assurance best practice approach to audit action tracking and the previous discussions at Staff Governance Committee regarding visibility of all audit activity under its' responsibility.

Key messages in the report included: -

(i) There were no new audit recommendations or revised targets since the previous update provided at the November 2025 meeting of the committee.

(ii) Following approval at the November committee meeting action point 11 – Staff Governance Annual report and action point 12 – Development of the People Strategy these were now marked as complete on Pentana.

(iii) The proposal was put forward for closure of the below actions:

   a. Management of Sickness Absence: Action Point Reference 6 – Absence Reduction Targets 2025/26
   b. Management of Sickness Absence: Action Point Reference 1 – Risk Control Assurance.

(iv) Supplementary Staffing Audit Report would be included within the March reporting cycle.

(v) Additional actions following the finalisation of the ICE report would be highlighted within the report shared at the March meeting of the committee.

The Staff Governance Committee: -

- **Was content with the progress report and action updates provided.**
- **Approved the closure of the proposed action points.**

11. Culture Change and Compassionate Leadership Program Update

The Staff Governance Committee received the 'Culture Change and Compassionate Leadership Programme Update' from Mrs Jo Tolland to outline the progress that had been made to make this work business as usual.

Key messages in the report included: -

(i) Following mobilisation of all 8 projects and definition of their key deliverables, work would progress with embedding this work into routine operations. Managing the transition to business as usual had started over six months ago through several workshops.

(ii) These sessions were carried out with the intent to raise awareness of the requirement for staff to take ownership prior to the conclusion of the programme to ensure a successful transition.
(iii) A whole system approach had been taken when considering the culture score recognising the need for a collaborative approach.
(iv) A consistent measure for this programme of work had been staff turnover recognising the significant drop since the highest recorded figure of 15.5% in December 2022 to now being around 8%. This could be reflected as staff recognising and feeling confident in the changes being made to the culture across the organisation.
(v) The focus for the remainder of the life cycle would be to ensure that future deliverables were defined to be embedded within the organisation's objectives.
(vi) The Strategic Workforce Planning Group would obtain responsibility of tracking progress and ensuring this work remained aligned to the corporate objectives.
(vii) Kevin Reith shared a presentation on the range of data that had been pulled together to populate the cultural indicator score. Culture could be measured through a wide range of metrics and the slides presented show the initial draft of triangulating this data to produce the appropriate scoring.
(viii) A dashboard had been developed within pentana to allow managers to have oversight of the culture within their team. Having all data contained within one system allowed for outliers to be easily identified, highlighting areas that required focus work.

The following points were raised in discussion: -
(i) The committee commended the work that had been carried out by the team and the progress with improving the culture across the organisation.
(ii) Recognition was given to the use of a cultural indicator score as an initial step but noted was the requirement for more substantial information to be available detailing the trends and functionality of this work to determine outliers and hotspots.
(iii) Recognised both the value of a single score, but also the risks (e.g. the score becoming the focus rather than the underlying issues).
(iv) Highlighted were the linkages to the Quality Management System (QMS) and the need to ensure these frameworks align without duplicating information and create a single source of data.
(v) Concerns were raised on the effectiveness of this work down to team levels as the use of score could reflect a team achieving the expected metrics, but the culture might not be suitable.
(vi) There was some uncertainty as to whether the proposed Learning System for Culture was necessary, especially given apparent overlaps with other quality improvement processes.
(vii) Confirmation was provided that an update would be shared at the March committee meeting on the appropriate governance structure to monitor embedding this work into business as usual and the timeframe of implementation.
(viii) Requested that communication be circulated to the committee outlining the timetable for reporting to NHS Forth Valley Board and the necessary Governance Committee's on the development of the draft measures moving forward.

The Staff Governance Committee:

- **Noted the proposed use of a single cultural indicator score as an initial indicator and requested an update taking into account the Committee's comments.**
- **Requested an update at the next meeting on the embedding of this work and the anticipated timetable.**
- **Recognised the linkage with other qualitive systems and that there were a number of other factors to be taken into consideration when measuring culture, not just figures.**

12. iMatter Update

The Staff Governance Committee received an 'iMatter Update' by Mrs Jenny McCusker to provide a comparison of NHS Forth Valleys iMatter results to the national results.

Key messages in the report included: -

(i) The Employee Engagement Index (EEI) score within NHS Forth Valley was in line with the national scoring of 77%. This was the highest recorded response for NHS Forth Valley since 2021.

(ii) There had been a slight decrease in responses received although still in line with national figures this could be due to the team confirmation by managers was not completed in a timeously manner. This meant that some people could not complete the iMatter questionnaire last year.

(iii) Work was underway to ensure the teams that were not included within the responses last year would be incorporated on this year's cycle.

(iv) The iMatter timeline for 2026 was included within the paper which was due to commence in April.

The following points were raised in discussion: -

(i) Information populated from the questionnaire was used to populate the EEI and shared with managers and teams. As a result of the feedback, discussions should take place to agree an action plan to focus on areas of improvement.

(ii) Lack of achieving100% completion of actions plans was queried due to the expectation for all teams to submit an action plan. This was reflective of the necessary conversations to produce an action plan not taking place despite the team's requirement to take accountability for their own progress.

(iii) All teams receive a feedback report but for those with a limited number of responses these reports would be amalgamated to maintain confidentiality.

(iv) Comments were raised on the requirement to be ambitious with achieving higher than the national average and provide assurances to staff that opinion matters in making a difference to increase engagement.

(v) Noted was that iMatter was a mandated questionnaire that organisations must comply with. Work was being undertaken by Jenny and her team to ensure the feedback was meaningful. Consider would be given to what level of information can be shared given the confidentially to provide assurances to the committee of the steps following completion and the actions plans being implemented.

The Staff Governance Committee: -

- **Noted the report.**
- **Requested feedback be shared on an annual basis to outline how the information gathered from this exercise benefits the organisation, including implementation of action plans, whilst maintaining confidentiality.**

13. Once For Scotland Policies

The Staff Governance Committee received an update on the 'Once for Scotland Policies' by Ms Linda Robertson to provide an update on the implementation of the NHS Scotland Workforce Policies.

Key messages in the report included: -

(i) The Scottish Workforce and Staff Governance (SWAG) formally approved the 10 workforce policies refreshed under phase 3 of the Once for Scotland NHS Scotland Workforce Policies Programme.

(ii) Subject matter experts were involved in moving forward with these workforce policies, including Cameron Raeburn for Health & Safety related policies. All other policies were in line with Emergency Planning, Occupational Health and Public Health.
(iii) A slide deck would be populated during the soft launch with staff side colleagues which would be published on the staff intranet.
(iv) The official launch date was yet to be confirmed but hopefully a date could be shared with the committee at the next meeting.

The following points were made in discussion: -
(i) Confirmed was that following the updated policies being published on the intranet these would be cascade through the organisation by HR managers and Directors to ensure staff at all levels were informed of the changes.

The Staff Governance Committee: -

- **Noted the report.**

14. Whistleblowing Activity Performance Report

The Staff Governance Committee received the 'Whistleblowing Activity Performance Report' by Karen Goudie to provide an update of whistleblowing activity across NHS Forth Valley.

Key messages in the report included: -
(i) To date there had been a total of 26 cases for Whistleblowing, there had been an additional 5 that were not deemed whistleblowing and were signposted to the appropriate routes.
(ii) 10 cases were managed under stage 1 and 16 under stage 2.
(iii) There had been 5 cases upheld by INWO relating to NHS Forth Valley whistleblowing concerns. This would soon increase to 6 but the finalised report had not been published and once more detail was available the committee would receive a further update.
(iv) Work was underway with INWO to enhance internal process and communications and reinforce transparency and accountability.
(v) From previous concerns of the Staff Governance Committee and feedback received from the Culture Programme, the distinction between Speak Up and Whistleblowing was reflected within the report. This included highlighting the points of contact and outlining the expectations from both services for staff and the organisation.
(vi) No concerns had been raised by staff but in cognisance of the concerns raised from committees' opportunities were being explored with Stirling University on the possibility of a joint evaluation on the merger of the processes.
(vii) To date 65 enquires had been received by the Speak Up service and the thematics of these included Bullying & Harassment, Patient and Staff Care, Staffing levels and Re-Banding.

The following points were raised in discussion: -
(i) The evaluation was a welcomed approach, but it was expressed that the differences between the processes could be articulated further to provide further clarity for staff.
(ii) Concerns were raised on the level of authority of Speak Up ambassadors recognising that not all staff members would be comfortable approaching a senior manager or a director to raise concerns. Assurances were provided that Speak Up operated through a generic inbox so not all concerns would be received by a Director but these points raised would be taken into consideration.
(iii) Committee was informed that the Scottish Hospital Inquiry final submissions were taking place from core participants including whistleblowers and there may be a possibility of national recommendations from this inquiry.

The Staff Governance Committee:

- **Recognised the need for clarity on the linkages of Speak Up and Whistleblowing and the nature of the confidential contacts.**
- **Would receive an update of the discussions taking place with Stirling University on the opportunity of a joint evaluation.**
- **Were assured on the effective nature of the Speak Up and Whistleblowing processes.**

15. Strategic Risk Register

The Staff Governance Committee received an update on the 'Strategic Risk Register' presented by Miss Vicky Webb to provide an update of the position as of November 2025, focusing on the risks aligned to the Staff Governance Committee

Key messages in the report included: -

(i) The strategic risks aligned to the Staff Governance Committee remained static and a reduction to the risk score of SRR009: Workforce Plans was highlighted. As a result of this reduction there had been a shift in the appetite profile for the Forth Valley NHS Board.

(ii) There were no risks within the Board's appetite, 33% were within the Board tolerance and 67% were out with both appetite and tolerance levels.

(iii) There were no overdue actions in this reporting period with 4 actions being completed.

The following points were raised in discussion: -

(i) The committee recognised the work that had been undertaken to assist with the reduction in score of SRR009: Workforce Plans.

(ii) Comments were raised on the potential to review the risk scoring for SRR019: Culture & Leadership following an update on the move to business as usual. Confirmation was provided that once things had began to progress with the move to business as usual and actions were implemented the risk could be reviewed but it felt premature at this stage.

(iii) Following comments on the timelines for completion of actions to ensure risks were within risk appetite it was confirmed that conversations were taking place on the utilisation of target dates to ensure appetite was achieved and the steps necessary if this was not the case.

The Staff Governance Committee: -

- **Endorsed the current assessment of the risks aligned to the committee.**

16a. Area Partnership Forum Minute 24.08.25 & 28.10.25

The Staff Governance Committee **noted** the Area Partnership Forum Minutes.

16b. Clackmannanshire & Stirling Joint Staff Forum

The Staff Governance Committee **noted** the Clackmannanshire & Stirling Joint Staff Forum.

17. Any Other Competent Business

There was no other competent business raised.

18. Matters to Raise at Board and Reflections

Mr Fairbairn confirmed that the below matters would be raised at Board:

- The committee would like to understand the timeline ant their involvement with the People Strategy
- Reports provided on PDPR compliance and Absence Management were more positive than previous reports in terms of activity and actions being undertaken. Although the committee would like a better understanding of the timelines for this work.
- Staff Governance Committee remit being done by correspondence.

- On the relative matters of culture and iMatter, recognised was the need to highlight the important aspects for NHS Forth Valley.

On reflection of the meeting the below was raised:

- There was a request to the committee to be rigorous with what's included within the papers and the use of hyperlinks would be sufficient in some areas rather than copying in extensive supporting reports.
- It was felt that meetings were becoming more honest and efficient in their discussions, but work could be done to refine the asks within papers.
- In line with the work underway for the culture of the organisation, this could be taken into consideration during discussions.

Mr Martin Fairbairn shared that this was Robert Clark's last meeting of the Staff Governance Committee. Robert was commended for his work as the Employee Director and thanked for his support to the Staff Governance Committee.

Subject to the required approvals, Ms Karren Morrison would be taking over the position of Employee Director.

19. Date of Next Meeting
Tuesday 10 March 2026 at 9:00am, Boardroom Carseview House, Stirling

STRATEGIC PLANNING, PERFORMANCE & RESOURCES COMMITTEE
Tuesday 26 May 2026

7.4 Minute of the Strategic Planning, Performance & Resources Committee Meeting held on Tuesday 31 March 2026

For: Ratification

Minute of the Strategic Planning, Performance & Resources Committee Meeting held on Tuesday 31 March 2026 at 11.00am in the Boardroom, Carseview House.

Present:
Ms Neena Mahal (Chair)
Mrs Kirstin Cassells (Non-Executive Director)
Cllr Fiona Collie (Non-Executive Director)
Mr Martin Fairbairn (Non-Executive Director)
Cllr Scott Farmer (Non-Executive Director)
Ms Alison Jaap (Non-Executive Director)
Mr Gordon Johnston (Non-Executive Director)
Cllr Fiona Law (Non-Executive Director)
Mr Stephen McAllister (Non-Executive Director)
Professor Clare McKenzie (Non-Executive Director)
Ms Karren Morrison (Non-Executive Director)
Mr Allan Rennie (Non-Executive Director)
Mr Finlay Scott (Non-Executive Director)
Mr John Stuart (Non-Executive Director)

In Attendance:
Mrs Elsbeth Campbell (Head of Communications)
Mr Tom Cowan (Head of Strategic Planning Performance & Transformation, Falkirk IJB)
Mrs Morag Farquhar (Director of Facilities)
Ms Wendy Forrest (Head of Strategic Planning & Health Improvement, Clackmannanshire and Stirling IJB)
Mr Jack Frawley (Board Secretary)
Professor Karen Goudie (Executive Nurse Director)
Mrs Sarah Hughes-Jones (Head of Information Governance) Item 12
Mr Scott Jaffray (Director of Digital)
Ms Deborah Lynch (Programme Manager)
Ms Jackie McEwan (Corporate Business Manager)
Professor Ross McGuffie (Chief Executive)
Ms Kerry Mackenzie (Acting Director of Strategic Planning and Performance)
Ms Fiona Murray (Head of Service for Emergency & Inpatient Services)
Mr Kevin Reith (Director of People) left the meeting at 11.30
Mrs Jillian Thomson (Deputy Director of Finance)
Miss Vicky Webb (Head of Risk Management)

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1. Welcome, Apologies for Absence and Confirmation of Quorum
There were no apologies. The meeting was quorate.

Jennifer Borthwick, Jennifer Champion, Garry Fraser, Andrew Murray, Scott Urquhart and Gail Woodcock were not in attendance.

2. Declarations of Interest
There were no declarations of interest.

3. Minute of Strategic Planning, Performance & Resources Committee held on 16 December 2025

The minute of the meeting held on 16 December 2025, subject to previous electronic circulation and committee member approval, was confirmed as an accurate record.

4. Matters Arising from the Minute / Action Log

The Action Log was reviewed by the Chair and consideration was given to the actions still in progress.

It was noted that the majority of actions were complete and would be removed from the action log.

Action 137 was highlighted as ongoing; a full mapping exercise was underway, reported as live and progressing well, with further updates to be brought to future meetings.
Actions 170 and 171 were identified as the remaining open items at this stage:

The Strategic Planning, Performance & Resources Committee approved the Action Log.

5. Chief Executive Update

The Strategic Planning, Performance & Resources Committee received a verbal update from the Chief Executive which included:

(i) **Robotic surgery:** The robotic system had arrived on site and been successfully installed. The 31 March implementation timeline had therefore been met, which represented a positive delivery milestone.
(ii) **Prisoner healthcare – Polmont FAIs:** The Ministerial Assurance Board process had concluded, with all NHS Forth Valley actions completed except for the risk-sharing agreement with the Scottish Prison Service, which was substantively complete and awaiting final SPS sign-off. Learning from the FAIs would be shared nationally through the Executive Leads Group for Prisoner Healthcare in May, followed by dissemination to Board Chief Executives across Scotland.
(iii) **Inspection activity:** An unannounced follow-up inspection of the hospital front door had taken place, with additional information currently being provided to inspectors. Preparatory work for the Child Sexual Abuse and Exploitation inspection was also underway, with the scope having progressed to a national inquiry.
(iv) **Front door staffing, flow and workforce implications:** The SLT had received CFSD analysis on front door staffing, which highlighted a marked drop in out-of-hours performance linked to decision-maker availability. Work was underway to align staffing levels and skill mix with demand and flow patterns, to aid performance. SPPRC members requested sight of the CFSD report, which would be shared alongside NHS Forth Valley's analysis and proposed actions once internal work was complete. Potential financial implications were noted, with mitigation options, including service redesign, being explored through a whole-system approach.

The Strategic Planning, Performance & Resources Committee noted the verbal update.

Action:

(1) The CFSD report would be shared alongside NHS Forth Valley's analysis and proposed actions once available. Ross McGuffie

6. Strategic Planning, Performance & Resources Committee – Terms of Reference

The Strategic Planning, Performance & Resources Committee considered a report, presented by Jack Frawley, which presented the Committee Terms of Reference for recommendation to the Board.

Key messages in the report included:

(i) There was a single amendment, shown in track changes within the document. This was reflective of feedback previously provided.
(ii) It was noted that horizon scanning remained a core element of the Committee's remit, reflecting its role as a strategic forum for non-executive consideration of emerging issues.
(iii) The Committee were advised that horizon scanning was already supported in practice, particularly through the Chief Executive's verbal updates, which regularly highlighted emerging and system-wide issues.
(iv) The Terms of Reference supported the Committee's role within the wider Board governance framework, with recommendations made onward to the Board rather than approval granted directly by the Committee.
(v) It was noted that the paper formed part of a wider programme of committee and governance review, linked to forthcoming Board development discussions and alignment with the Code of Corporate Governance.

The following points were made in discussion:

(i) Members questioned whether horizon scanning was accurately reflected in the Terms of Reference. Assurance was provided that this remained a core strategic function and should be retained.
(ii) Members suggested introducing a standing agenda item or clearer agenda structure for horizon scanning or emerging issues. This was welcomed and would be considered in future agenda planning.
(iii) Clarification was sought around how the Terms of Reference would be reviewed and progressed. It was confirmed that, following Board development discussions, any revisions would progress through the Code of Corporate Governance, Audit & Risk Committee and then the Board.
(iv) It was recognised that forthcoming Board development sessions would provide an opportunity to reflect on the effectiveness and operation of SPPRC. It was confirmed feedback would inform any further refinement of the Terms of Reference.
(v) Confirmation was sought and provided that the Committee were being asked to recommend the revised Terms of Reference to the Board, rather than approve them.

The Strategic Planning, Performance & Resources Committee:

(1) agreed to refer the Terms of Reference for onward submission to the Board.
(2) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified

7. Finance

(a) Finance Report

The Strategic Planning, Performance & Resources Committee received the Finance Report presented by Mrs Jillian Thomson, which provided assurance on the organisation's financial position, sustainability and key financial risks.

Key messages in the report included:

(i) The Committee was advised that the Month 11 financial position remained unchanged from that previously reported to the Board, with NHS Forth Valley forecasting break-even against both revenue and capital resource limits.

(ii) The forecast position remains subject to key risks, notably confirmation of IGIB outturns and receipt of outstanding national funding allocations, including National Treatment Centre funding.

(iii) NHS Forth Valley received additional non-recurrent funding from Scottish Government late in the financial year, which was intended to be used flexibly to support future financial resilience, including providing headroom for 2026/27 risks.

(iv) The year-to-date savings position was reported as £7.3m behind plan, with pressures concentrated primarily within acute services and emergency care, and these areas remain a focus of ongoing management action.

(v) Capital programme slippage of approximately £1.7m was reported, relating to national delays in programmes such as Order Comms and LIMS, with funding requested to be carried forward into 2026/27.

The following points were made in discussion:

(i) Members reflected on the potential behavioural impact of persistent overspends on budget holders. Members were advised that unachievable historic savings targets were removed from plans in 2025/26 to alleviate pressure, with enhanced engagement now focused on setting realistic baselines and strengthening financial scrutiny.

(ii) In response to questions on early warning mechanisms for savings delivery, it was confirmed that savings performance is monitored monthly, supported by fortnightly meetings of the Financial Stewardship Programme Board, with corrective actions and invest-to-save proposals progressed as required.

(iii) Members sought assurance that capital programme slippage did not present a financial risk. It was confirmed this reflected timing only, with no in-year funding requirement and a formal request submitted to Scottish Government to carry funding forward.

(iv) Concerns were raised regarding rota compliance and medical workforce costs, including potential patient safety implications. Assurance was provided that rota redesign was underway, compliance was overseen through the Medical Workforce Group, and national contract negotiations remain ongoing.

(v) Members requested clearer and more consistent RAG ratings within the financial sustainability report. This was acknowledged, with confirmation savings and sustainability reporting would be refreshed, with clearer definitions and improved assurance in future reports.

The Strategic Planning, Performance & Resources Committee:

(1) Noted that a break-even position against both revenue and capital sources was projected for 2025/26 subject to identified risks in the last month of the year.

(2) Noted that the 3-year financial plan was being presented to the NHS Board for formal approval on 31 March 2026.

(3) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the

delivery of objectives and where improvements were needed, clear actions had been identified.

Action:

(1) Exploration of flexibility with Local Authorities on developer contributions for refurbishment of existing premises. Morag Farquhar

(b) Financial Sustainability Oversight

The Strategic Planning, Performance & Resources Committee received the Financial Sustainability Report presented by Mrs Jillian Thomson, which provided assurance on longer-term financial sustainability risks and the effectiveness of mitigating actions

Key messages in the report included:

(i) Colleagues were advised of Medical workforce sustainability, including reliance on premium staffing. Rota compliance was identified as a structural risk requiring sustained system-wide mitigation rather than short-term financial correction.

(i) The report set out non-cash-releasing sustainability actions, recognising that some actions are designed to improve resilience, safety and service continuity rather than deliver immediate savings.

(ii) A RAG-rated sustainability framework was presented to support assurance, aligned to national reporting requirements, including the Scottish Government sustainability grid.

(iii) The paper supported the Committee's role in providing ongoing assurance to the Board on whether financial sustainability risks are being appropriately identified, monitored and mitigated over time.

The following points were made in discussion:

(i) Members queried the meaning and consistency of RAG ratings, particularly where actions showed no associated savings; clarification was provided that the framework reflected progress against enabling actions, not solely financial impact, and confirmed that narrative explanation would be strengthened in future reports.

(ii) Clarification was sought on whether rota non-compliance constituted a safety risk as well as a financial risk. Assurance was provided that rota compliance was monitored through established workforce governance and that safety considerations were integral to ongoing redesign work.

(iii) Members requested greater visibility of progress and the trajectory for reducing medical workforce costs; it was confirmed further detailed reporting would be developed to support assurance.

(iv) Questions were raised regarding the extent to which sustainability actions were constrained by national dependencies, including contracts and policy; it was confirmed that while some actions are nationally constrained, local mitigation and redesign activity continues in parallel.

(v) The Committee emphasised the need for clearer assurance narrative, distinguishing between actions that deliver financial savings and those that strengthen system sustainability. This was acknowledged with confirmation that sustainability reporting would be refined accordingly.

The Strategic Planning, Performance & Resources Committee noted the overview of the Financial Stewardship Programme Board and delivery of the Financial Sustainability Action Plan.

Actions:

(1) Review and clarify RAG rating methodology against the 15 box grid. Scott Urquhart

(2) Future Reports to be refined to provide clearer assurance narrative including actions to reduce medical workforce costs and governance arrangements to oversee progress. Scott Urquhart

(c) National Treatment Centre.

The Strategic Planning, Performance & Resources Committee considered a report presented by Professor Ross McGuffie, which updated the Committee on the current status of the National Treatment Centre, to clarify activity targets and system impacts, and to provide assurance on risk, governance and next steps pending resolution of outstanding issues.

Key messages in the report included:

(i) The report provided an update on the current status of the National Treatment Centre, confirming that the position remained unchanged from that reported within the paper. Professor McGuffie confirmed that resolution remained dependent on external approvals.

(ii) It was confirmed that planning for service delivery had commenced in parallel, including consideration of how NTC capacity will support wider bed modelling and elective care planning across the acute site.

(iii) The report clarified the elective activity targets, confirming that the NTC target of 1,086 procedures sat alongside an additional 400 orthopaedic procedures delivered locally, giving a combined target of 1,486.

(iv) Performance against the combined target was reported as 1,343 procedures completed, with assurance that delivery would be at or close to target by year end.

(v) The NTC was identified as a key enabler for elective recovery and system flow, particularly through the release of existing ward capacity currently being used to support planned care.

The following points made in discussion:

(i) A query was raised around the operational difference that would result from the NTC, given that activity was currently being delivered without the building. In response it was confirmed the NTC would provide a fully ring-fenced elective facility, protected from winter pressures, with dedicated staffing and improved infection prevention control.

(ii) Clarification was sought on the timeline for resolving outstanding building issues, confirmation that we were doing everything possible within our control to resolve the issues and whether further delays were likely. In response, it was advised that whilst a decision was expected by the end of April, there was a risk of further delay depending on which remediation option was agreed.

(iii) Concerns were raised around the impact of releasing the 14 elective beds currently in use and whether this could improve unscheduled care flow; it was confirmed that this would be incorporated into wider site bed modelling, including assessment of specialty mix and flow benefits.

(iv) Questions were asked about the adequacy of the NTC staffing model, including cover for absence and resilience. Professor McGuffie acknowledged the concerns, and confirmed that benchmarking suggested staffing levels may be light. It was noted this was subject to ongoing discussion with Scottish Government.

(v) Members expressed significant concern about reputational, governance and audit risk, including how the project had reached its current position. In

response, the complexity of the procurement and assurance landscape was recognised, with confirmation that Scottish Government is fully sighted on the issues and the actions being taken. Members sought assurance that clear audit trails of decision making and assurance processes were in place. This would be expanded on in future reporting. Members also asked for consideration of the risks of the NTC project being escalated by SLT from an operational risk to a corporate strategic risk.

The Strategic Planning, Performance & Resources Committee:

(1) Noted the status of the National Treatment Centre programme.

(2) Noted that the timeline for ward completion and associated Key Stage Assurance Review processes is not confirmed and will require resolution of outstanding compliance issues as advised by NHS Scotland Assure.

(3) Considered that the report provided limited assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified, whilst recognising that many of the factors were outwith our control.

Actions:

(1) Ensure action log/audit trail is compiled setting out key decisions, actions taken, escalation points and governance arrangements. Ross McGuffie

(2) Circulate previous briefings on the NTC to all members, particularly to apprise new Members of the Committee of previous discussions. Scott Urquhart

(3) SLT to consider the risks associated with the NTC building issues and review whether this merited escalation from an operational to a corporate strategic risk. Scott Urquhart

8. Performance Report

The Strategic Planning, Performance & Resources Committee considered a report presented by Ms Kerry Mackenzie, which provided assurance on current organisational performance and enabled scrutiny of key risks and trends.

Key messages in the report included:

(i) The Committee received an overview of organisational performance across planned care, urgent and unscheduled care, delayed discharge and workforce indicators, with contributions from executive and operational leads.

(ii) Planned care performance, presented by Fiona Murray, remained focused on delivery of the 52-week standard, supported by a locally agreed stretch ambition of 40 weeks, while recognising the prioritisation of urgent and cancer pathways.

(iii) Urgent and unscheduled care performance, presented by Deborah Lynch, showed improvement in average length of stay, attributed to sustained system changes rather than seasonal variation.

(iv) Delayed discharge performance continued to be affected by guardianship delays, with variation across partnership areas and constraints linked to statutory processes.

(v) Workforce performance indicators, including PDP completion, remain variable across directorates and are subject to ongoing management through directorate reviews and Staff Governance arrangements.

The following points were made in discussion:

(i) Members questioned whether improvements in length of stay were sustainable; Deborah Lynch confirmed that improvements reflected embedded system changes, including Discharge Without Delay, criteria-to-reside, ward-based discharge coordination and strengthened grip on complex discharges.

(ii) Clarification was sought on the increase in guardianship delays. It was confirmed that this reflected the legal nature of the process, mental health officer capacity constraints, court scheduling and earlier identification through criteria-to-reside, with enhanced weekly oversight now in place.

(iii) Members expressed concern that urgent and unscheduled care reporting did not provide sufficient assurance against the agreed improvement strategies; this was acknowledged with confirmation reporting would be strengthened, with clearer milestones and narrative against the rapid improvement plan.

(iv) Questions were raised regarding PDP completion rates and variation across directorates; Fiona Murray clarified the distinction between PDPs signed off and those in progress, confirmed variable performance across areas, and advised that this was being actively managed through directorate reviews and the Staff Governance Committee.

(v) Members sought clarity on planned care prioritisation, with consideration between 12-week, 52-week and cancer standards. In response it was confirmed that prioritisation reflected clinical urgency, workforce availability and diagnostic capacity, with particular pressures noted in urology due to long-term absence and tertiary dependencies.

(vi) In response to discussion on performance reporting and the need for a sharper focus on areas of concern and mitigating actions, Ms Mackenzie indicated that she proposed to set up a SLWG with NXD involvement to develop the performance report to address this.

The Strategic Planning, Performance & Resources Committee:

(1) Considered the latest performance data within the Performance Report noting the Area of Focus – Urgent & Unscheduled Care, and Priority Areas of Performance.

(2) Considered the progress made in respect of the number of patients waiting over 52 weeks for a new inpatient appointment and for an inpatient/daycase procedure.

(3) Considered that the report provided assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified although it was acknowledged that Urgent and Unscheduled Care actions needed clearer monitoring to ensure that they were delivering the necessary improvements.

Action:

1. **Take forward SLWG reviewing performance reporting for the Committee and Boards.** Kerry Mackenzie.

9. Population Health and Care Strategy Delivery of Plan / Programme of Work 2026/27

The Strategic Planning, Performance & Resources Committee considered a report presented by Professor McGuffie, which set out the proposed Programme of Work for 2026/27 to deliver the Population Health and Care Strategy and support effective governance and assurance.

Key messages from the report

(i) The report presented a draft Programme of Work for 2026/27, aligned to the Population Health and Care Strategy and bringing national and local commitments into a single delivery framework.
(ii) The approach replaced multiple standalone plans with a clear articulation of priorities, deliverables, accountable Directors and governance routes.
(iii) Six strategic themes underpinned the programme, supported by key enablers such as workforce, digital, quality and safety.
(iv) The 2026/27 programme would form the basis of Executive objectives and performance management.
(v) The programme responded to Board feedback around the need for clearer delivery, key milestones and assurance.

The following points were made in discussion

(i) Members sought assurance that this represented the single organisational delivery plan. It was confirmed this was intended to be the authoritative plan for delivery and assurance.
(ii) Clarification was requested on timescales with confirmation that the programme would be finalised in April. This would enable Executive objectives to be agreed through the Remuneration Committee.
(iii) Members questioned how duplication across workstreams would be avoided. It was confirmed that the strengthened Programme Board and Whole System Leadership Team oversight would support alignment.
(iv) Clarification was sought on governance and reporting routes, with a request that Board-level governance and operational delivery routes were clearly defined within the programme.
(v) Members emphasised the importance of long-term outcome measures and this was agreed with confirmation work was underway to develop outcome metrics aligned to national work.

The Strategic Planning Performance & Resources Committee:

(1) Endorsed the approach being taken to create a single action plan for the delivery of the Population Health and Care Strategy along with other national frameworks, which will be utilised to set out the 2026/27 Programme of Work.
(2) Considered that the report provided assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

10. Population Health Update – Direction of Travel

The Strategic Planning, Performance & Resources Committee considered a report presented by Professor McGuffie, which provided an update on the direction of travel for population health and how this was shaping decision-making and priorities across the system.

Key messages from the report:

(i) The report provided an update on the emerging direction of travel for Population Health, building on the Population Health and Care Strategy and aligning activity across the system.
(ii) Population health was positioned as an organisational lens, influencing decision-making across acute, planned care, urgent and unscheduled care and community services.

(iii) Early progress was highlighted in embedding prevention and value-based approaches, with examples from urgent and unscheduled care, planned care and theatres.
(i) The importance of system-wide collaboration, including Community Planning Partnerships and local authorities, was emphasised in addressing population health priorities.
(ii) The report signalled a shift towards long-term outcome measures, alongside national alignment, to track the impact of population health interventions over time.

The following points were made in discussion:
(i) Members sought clarification on how population health principles were being applied in practice; examples were provided including preventative approaches within urgent and unscheduled care and value-based decision-making in planned care pathways.
(ii) Questions were raised around the balance between short-term pressures and long-term prevention; the challenge was acknowledged with confirmation that population health was intended to shape immediate decisions, not solely over a longer term.
(iii) Members queried how prevention investment priorities would be identified and it was confirmed that work was underway, including consideration of areas such as healthy weight management, aligned to both local and national priorities.
(iv) Clarification was sought on the role of education, local authorities and Community Planning Partnerships; with confirmation that education and wider partners were integral to delivery and that collective prioritisation across Community Planning Partnerships was being strengthened.
(v) Members emphasised the need for clear outcome measures to measure success and assurance was provided that development of long-term population health metrics was underway, aligned to national population health work and would be brought forward for further discussion.

The Strategic Planning, Performance & Resources Committee:
(1) noted the progress being made in relation to Population Health
(2) considered that the report provided assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

11. Risk Management

(a) Risk Management Framework

The Strategic Planning, Performance & Resources Committee considered a report presented by Ms Vicky Webb, which provided assurance on risk management arrangements, including the Risk Management Framework and Strategic Risk Register.

Key messages from the report included:
(i) The report presented a revised Risk Management Framework, refocused from a detailed strategy to a principles-based framework, with procedural detail separated into supporting documents. The role of the SLWG comprising NXDs was acknowledged in driving this work.
(ii) The framework clarified NHS Forth Valley's approach to risk management, including recognition of different risk categories in healthcare and the concepts of predictive, proactive and reactive risk management.

(iii) A revised risk appetite statement was included, setting out the Board's tolerance across different risk domains to support consistent decision-making and escalation.
(iv) The framework strengthened governance and oversight, clarifying how risks flowed between operational, strategic and Board-level registers.
(v) The report supported ongoing work to embed a more mature and consistent risk culture, aligned to Audit & Risk Committee oversight and the wider Board governance framework.

The following points were made in discussion:
(i) Members sought clarification on whether the framework allowed sufficient flexibility to escalate risks outwith the current 6 monthly schedule. It was confirmed that escalation can occur when required and it was agreed to refine wording to avoid any unintended restriction.
(ii) Questions were raised about the interaction between NHS Board and IJB risk appetite, particularly where similar risks may be scored differently. It was confirmed that while risk scoring may differ, shared understanding and visibility across organisations was maintained.
(iii) Clarification was requested on the proposal to continue the existing short-life working group. It was agreed that this would continue as a time-limited group, with a defined review period, rather than a standing advisory group to take forward further areas of work discussed by the Board at its Board seminar on risk.
(iv) Members queried whether controls should be more explicitly articulated within the framework. It was confirmed that a controls section would be incorporated prior to submission to the Board.
(v) Discussion highlighted the importance of clear escalation routes and assurance, with members emphasising the need for transparency where risks move between operational and strategic levels. Assurance was provided this would be reflected in the final framework.

The Strategic Planning, Performance & Resources Committee:
(1) Considered and commended the Risk Management Framework for onward approval at the FV NHS Board.
(2) Considered and commended the risk appetite levels for the Board as noted in the Risk Management Framework, for onward approval at FV NHS Board.
(3) Noted the work of the SLWG regarding the progression of the Risk Appetite approach and that the previous work of the SLWG has been completed with a desire for the group to continue on a defined time bound basis to take forward other areas of work. Future work would include a review of the previously agreed areas: a. Review the Strategic Risk Descriptions b. Discuss the introduction of 'Time to Appetite' c. Discuss the concept of Risk vs. Issues and agree next steps.
(4) Considered that the report provided assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Actions:
(1) Update the Risk Management Framework to include an explicit section on controls prior to submission to the Board. Vicky Webb
(2) Amend the Risk Management Framework to clarify that risks may be escalated outside the scheduled twice-yearly review cycle where required. Vicky Webb

(3) Continue the existing Risk Management short-life working group on a time-limited basis, with a defined review point to confirm whether it should conclude. Vicky Webb

(b) Strategic Risk Register Update

The Strategic Planning, Performance & Resources Committee considered a report presented by Ms Vicky Webb which provided Committee with an update on the status of the Strategic Risk Register and support assurance that key strategic risks are being appropriately monitored and managed.

Key messages from the report included:

(i) The report provided an update on the current Strategic Risk Register, outlining the status of key strategic risks and associated mitigating actions.
(ii) It was confirmed that the Register reflects the highest-level risks requiring Board oversight, with alignment to the revised Risk Management Framework.
(iii) Several risks remain outside the Board's stated risk appetite, with mitigating actions in place and subject to ongoing monitoring.
(iv) The report highlighted the role of external dependencies, including national policy, funding and partner organisations, in influencing risk trajectories.
(v) The Strategic Risk Register continues to support assurance to the Board, with risks reviewed regularly through established governance routes.

The following points were made in discussion:

(i) Members sought clarification on the extended timescales associated with some risk actions, particularly those relating to estates and infrastructure. It was noted that these reflected national dependencies and worst-case planning assumptions; however, work was ongoing to accelerate delivery where possible.
(ii) Members queried Strategic Risk 11 (Digital and eHealth), noting the absence of a fully developed mitigation plan. Vicky Webb confirmed that a focused deep-dive review was scheduled, following which a more comprehensive mitigation plan will be brought forward.
(iii) Clarification was requested on the Primary Care Sustainability risk, including the extension of the strategy's timescales. Colleagues were advised that while the Primary Care Strategy had been extended, mitigating actions continued in parallel and the overall risk position is not solely dependent on completion of the strategy.
(iv) Members discussed the process for escalation between the operational and strategic risk registers, with reference to recent discussion on the National Treatment Centre. It was confirmed that escalation decisions sat with the Strategic Leadership Team (SLT); however, concerns raised by Committees would be fed back for further consideration.
(v) The need for clearer narrative assurance within the Risk Register was noted, particularly to distinguish between risks that were within organisational control and those driven by external dependencies. Ms Webb acknowledged this and agreed to strengthen explanatory commentary in future reports.

The Strategic Planning, Performance & Resources Committee:

(1) Considered the latest performance data within the Performance Report noting the Area of Focus – Urgent & Unscheduled Care, and Priority Areas of Performance.
(2) Considered the progress made in respect of the number of patients waiting over 52 weeks for a new inpatient appointment and for an inpatient/daycase procedure.

(3) Considered that the report provided assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Action:

(1) Risk Register updates to include clearer narrative explaining control, dependency and assurance context. Vicky Webb

12. Information Governance

(a) Information Governance Update and Annual Report

The Strategic Planning, Performance & Resources Committee considered a report presented by Ms Sarah Hughes-Jones, which provided an update on Information Governance performance and presented the annual report for 2024/25.

Key messages from the report included:

(i) The Committee was informed that FOI performance had significantly improved, with 98% compliance for new requests in March and 100% compliance for internal reviews, representing a marked recovery.

(ii) A reportable IG incident relating to temporary inaccessibility of paper patient records due to shelving failure was highlighted, with mitigations in place and oversight by the Information Commissioner's Office.

(iii) The Annual Report acknowledged that capacity constraints within the IG function during the year had limited progress in some areas, despite a sound framework being in place.

(iv) The report identified a likely need for further investment in Information Governance, particularly to sustain assurance activity alongside compliance and disclosure workloads.

The following points were made in discussion:

(i) Members sought clarification around the patient records incident and clinical impact. Ms Sarah Hughes-Jones confirmed that temporary electronic records were used where required. A small number of appointments were cancelled and that the ICO had reviewed and closed the case subject to monitoring.

(ii) Questions were raised regarding oversight and governance arrangements for IG; it was clarified that IG reports through the Corporate Medical Director, were overseen by the Information Governance Group (with CIRO involvement), and provides assurance through this Committee and Audit & Risk Committee.

(iii) Members queried mandatory IG training compliance, noting low completion rates. This was recognised, however was consistent with wider e-learning challenges. However, responsibility sat with services and that additional support and engagement (including webinars and training needs analysis) is being put in place.

(iv) Clarification was sought on records management weaknesses, including disposal and filing controls. Ms Sarah Hughes-Jones confirmed that recruitment of a Corporate Records Manager in February would now enable development of a structured improvement plan.

(v) Members discussed whether the IG strategic risk could be de-escalated in future. In response, it was confirmed this would be achievable but was dependent on sustained improvement in records management controls and sufficient resourcing to provide ongoing assurance.

The Strategic Planning, Performance & Resources Committee:

(1) Endorsed the assurance activity noted in the Annual Report.

(2) Considered that the report provided assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

(b) Information Governance Strategic Risk Review

The Strategic Planning, Performance & Resources Committee considered an appendix presented by Ms Sarah Hughes-Jones, and Ms Vicky Webb which provided a review of information governance strategic risk to support Committee assurance.

Key messages from the report

(i) The report provided a focused review of the Information Governance (IG) strategic risk, including its current score, trajectory and alignment with the Strategic Risk Register.
(ii) It was noted that the IG strategic risk had shown improvement compared to previous periods, reflecting strengthened controls, improved FOI performance and stabilisation of governance arrangements.
(iii) Ongoing records management weaknesses were highlighted as a key factor preventing further de-escalation of the risk at this stage.
(iv) The report emphasised that sustained assurance, rather than one-off improvement, was required before the risk could be considered for de-escalation from the Strategic Risk Register.
(v) The review reinforced the importance of adequate capacity and capability within the IG function to maintain control effectiveness and provide ongoing assurance.

The following points were made in discussion:

(i) Members queried whether the IG strategic risk could now be de-escalated; Ms Webb advised that while progress has been made, de-escalation would be premature until records management controls were fully embedded and sustained.
(ii) Clarification was sought on what additional evidence would be required to support de-escalation and it was confirmed this would include demonstrable improvement in records management, consistent disposal practices and ongoing assurance activity.
(iii) Members highlighted the challenge of assuring IG controls at local service level; and it was acknowledged variation across services and confirmed that clearer ownership of controls and assurance mechanisms would be required.
(iv) Questions were raised regarding the reliance on SharePoint as an enabler for improved records management; it was confirmed that it presented an opportunity to improve structure and compliance but was not a standalone solution, requiring supporting policy and practice changes.
(v) Members noted the relationship between resourcing and assurance, querying whether current capacity was sufficient. It was acknowledged that additional investment may be required to ensure the IG team can sustain assurance activity alongside compliance demands.

The Strategic Planning, Performance & Resources Committee

(1) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

(c) Information Governance Group Minutes

The Strategic Planning, Performance & Resources Committee considered the Information Governance Group Minutes from 15 January 2026.

The Strategic Planning, Performance & Resources Committee noted the minutes.

13. Internal Audit

(a) Internal Audit Actions Follow Up

The Strategic Planning, Performance & Resources Committee considered a report presented by Ms Kerry Mackenzie, which highlighted the status of Internal Audit follow up actions aligned to the Committee for oversight.

Key messages from the report included:

(i) The report provided an update on progress against internal audit actions overseen by the Committee.
(ii) It was confirmed that no audit actions monitored by SPPRC are overdue at the time of reporting.
(iii) A number of actions were noted as due for completion on the day of the meeting, with assurance provided that these were expected to be completed as planned.
(iv) Two actions were identified with revised timescales, both expected to be completed within the next reporting period.
(v) The report provided assurance that governance arrangements for tracking and monitoring audit actions remain effective.

The following points were made in discussion:

(i) Members sought reassurance around actions due on the day of the meeting would be completed. It was confirmed that all were expected to be closed as planned.
(ii) Clarification was requested regarding the two actions with revised timescales; Ms Mackenzie advised that one was now due in April and one in May, with both anticipated to be completed in April.
(iii) Members noted that the Committee was in a strong position with no overdue actions, providing assurance on audit responsiveness.
(iv) Comment was made that some audit findings could appear overly granular, but members acknowledged the importance of maintaining a robust audit trail. It was confirmed that all findings were being addressed appropriately.
(v) Members encouraged a proportionate approach to policy-related actions, noting that where policies remained fit for purpose, re-endorsement rather than full redrafting should be considered. Ms Mackenzie confirmed this approach had been discussed at Executive level.

The Strategic Planning, Performance & Resources Committee:

(1) Noted the status of the current audit follow up actions aligned to the Committee.
(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

(b) Internal Control Evaluation 2025/2026

The Strategic Planning, Performance & Resources Committee considered a report presented by Ms Kerry Mackenzie, which provided assurance on internal control arrangements for 2025/26.

Key messages from the report

(i) Overall, the system of internal control was described as generally effective, with identified areas for further strengthening rather than fundamental weakness.
(ii) The evaluation draws together assurance from internal audit, external audit, inspections and management reviews, informing the Annual Governance Statement.
(iii) A small number of control weaknesses and improvement areas were identified, many of which are already subject to existing action plans and governance oversight.
(iv) The report supports the Board's statutory requirement to provide assurance on internal controls, aligning with Audit & Risk Committee scrutiny.

The following points were made in discussion

(i) Members sought clarification on whether the evaluation identified any material control failures. Assurance was provided that no significant or systemic control failures had been identified.
(ii) Questions were raised on the relationship between the Internal Control Evaluation and the Annual Governance Statement. It was confirmed that the evaluation directly informed the assurance statements provided in the Governance Statement.
(iii) Members queried whether identified weaknesses were already captured within existing audit actions or risk registers. Assurance was provided that these issues are being tracked through established governance routes.
(iv) Clarification was sought on how assurance from non-audit sources (e.g. inspections and reviews) was reflected. It was confirmed that these sources were explicitly considered within the evaluation process.
(v) Members emphasised the importance of ongoing monitoring and proportionality, noting that controls should be strengthened where required without creating unnecessary bureaucracy. It was confirmed this approach is reflected in current practice.

The Strategic Planning, Performance & Resources Committee:

(1) Noted the outcomes of the 2025/26 Internal Control Evaluation.
(2) Considered the audit findings of specific concern to the Strategic Planning, Performance & Resources Committee and the management responses.
(3) Considered that the report provided assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

14. Strategic Planning, Performance & Resources Committee Planner

The Strategic Planning, Performance & Resources Committee considered the 'Strategic Planning, Performance & Resources Committee Planner'.

The Strategic Planning, Performance & Resources Committee noted the Committee Planner.

15. Emergency Planning & Resilience Group Minute

The Strategic Planning, Performance & Resources Committee received the 'Emergency Planning & Resilience Group Minute' of the meeting held on 27 November 2025.

The Strategic Planning, Performance & Resources Committee noted the Emergency Planning & Resilience Group Minute.

16. Any Other Competent Business
There was no other competent business.

17. Risks, Reflections & Areas to Highlight to the NHS Forth Valley Board
The Committee reflected on key risks arising from the meeting, particularly the National Treatment Centre, and agreed that assurance and risk positioning should be revisited through SLT and highlighted to the Board. No additional actions were agreed.

18. Date and Time of Next Meeting
Tuesday 26 May 2026 at 9:30am, in the Boardroom, Carseview House.

The Chair closed the meeting at 1:30pm.

7.6 **RATIFIED** Minute of the Area Partnership Forum meeting held on Tuesday 17 February 2026 at 2 pm, via MS Teams.

Present: Robert Clark, Employee Director (Chair)
Emma Small, RCN
Janet Sneddon, RCM
Jenny McCusker, Head of Organisational Development
Jennifer Borthwick, Interim Chief Officer, Clackmannanshire/Stirling HSCP & IJB
Karen Goudie, Executive Nurse Director
Karen Leonard
Kevin Reith, Director of People
Linda Robertson, HR Manager Staff Governance
Lynsey Walker, British Dietetics Association
Michael Brown, Head of Workforce and Resourcing
Morag Farquhar, Director of Facilities
Nicholas Hill, GMB
Scott Urquhart, Director of Finance
Stephen Feltblower, BMA

In Attendance: Gordon Mackenzie, Localities Services Lead Falkirk HSCP
Diane Sharp, Clinical Nurse Manager Clackmannanshire & Stirling HSCP
Ewan Murray, Business & Governance Lead, Falkirk HSCP
Hazel Jamieson, Pharmacy Operational Services Manager (for Laura Byrne)
Charlie McCarthy, Unison (for Karren Morrison)
Tom Cowan, Head of Strategic Planning & Transformation for Falkirk HSCP/Head of Primary Care for Forth Valley
Sarah Smith, Corporate Services (Note)

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1. Apologies for Absence/Confirmation of Quorum

Apologies for absence were noted on behalf of: Carole Murray, Caroline Doherty, Garry Fraser, Gillian Tait, Greig Kelbie, Julie McIlwaine, Julie Mitchell, Karren Morrison, Laura Byrne, Linda McGovern, Ross McGuffie

2. Declaration(s) of Interest(s)

There were no declarations of interest made.

3. Draft minute of meeting held on 16 December 2025

The note of the meeting held on 16 December 2025 was approved as an accurate record, subject to the following amendment:

- Action 85 – ‘circle’ to be amended to ‘Serco’.

4. Action Log

The action log was reviewed and would be updated to reflect discussions.

63 **Partnership Agreement:** The Forum noted that the Partnership Agreement remains outstanding and required updating and progression.
73 **Absence Management Review Group):** It was confirmed that a written report has not yet been received and should be brought to a future meeting.
80 **Car Lease / Salary Sacrifice):** The Forum noted that work remains ongoing, with no new update provided and any proposal to return to EPS/APF when developed.

85 **Excessive Temperatures**: It was noted that the Serco feasibility study had not yet been provided, and the urgency of the issue was highlighted ahead of warmer weather.
90a **Workforce Process Clarification:** This action was not specifically revisited during the meeting and remains ongoing.
94 **Vandalism to Staff Cars – FCH:** It was confirmed that an additional CCTV camera will be installed, with timescales still to be confirmed.
95 **Workforce Policies Phase 3:** The Forum noted that national policies are expected to be published in early March 2026.
96a **Reduced Working Week:** Significant discussion took place, with confirmation that joint
96b communications and a clear governance paper must return to APF for assurance.

5. Items for approval

5.1 Early Evening Service Proposed Change

The Area Partnership Forum received a presentation from Gordon Mackenzie, Social Work Manager, Falkirk Health and Social Care Partnership, supported by Diane Sharp, Community Nurse Manager, outlining proposals for changes to the Early Evening Service staffing arrangements.

The changes were being requested in response to funding changes, with the intention of maintaining service continuity for patients throughout the afternoon, early evening, and night periods. The proposal involved adjusting staff working hours, which would allow for a reduction in the number of posts required. It was noted that current vacancies meant no redeployment would be necessary, and the change would contribute to achieving a required saving of £18,000. The importance of maintaining patient care continuity was highlighted, with assurance the proposed changes were intended to ensure 24/7 cover despite financial constraints.

The Forum was advised that consultation had taken place with staff side representatives and managers and that the service was considered safe to continue under the revised arrangements. An Equalities Impact Assessment had identified potential impact on female staff and those with caring responsibilities. Active engagement was ongoing to mitigate these areas.

In terms of the consultation process with affected staff, it was confirmed that all staff had been informed and offered one-to-one meetings, although none had yet requested these. It was agreed follow up would be undertaken to arrange these with a request for the process to be tracked for audit and governance purposes.

Concerns were raised regarding the risk of staff leaving because of the changes, particularly those with caring responsibilities. The Equalities Impact Assessment was discussed in detail, with explicit recognition of the female staff group and potential financial impacts. Staff side representatives emphasised the importance of following proper process and ensuring clear communication, noting that staff were awaiting further information.

The Forum approved the process for ongoing discussion with affected staff about shift changes.

5.2 Falkirk HSCP on-call rota

The Forum considered a paper outlining proposals to introduce a Falkirk Health and Social Care Partnership–led on-call rota, presented by Ewan Murray, Business & Governance Lead, Falkirk HSCP.

Colleagues were advised that the proposal had been created in response to Integration Joint Boards being designated Category 1 responders under the Civil Contingencies Act. It was explained that the proposal had been informed by previous learning and staff engagement and was intended to provide a clear, scheduled point of contact, supported by training and resilience arrangements.

Implementation was proposed from April 2026, with a review after six months and annually thereafter.

There was discussion around how the proposed rota would interface with existing NHS executive on-call arrangements with confirmation it would operate separately, with appropriate links to resilience and emergency planning colleagues. Staff side raised concerns regarding fairness, organisational change implications, and differences in on-call payments between NHS and local authority staff. Assurance was provided that Agenda for Change terms and conditions would apply for NHS staff, that appropriate organisational change processes would be followed where required and that the arrangements would be reviewed following implementation to ensure they were proportionate and did not duplicate existing on-call systems.

The Forum agreed to approve the formation and implementation of a Falkirk Health and Social Care Partnership–led on-call rota, subject to appropriate organisational change processes being applied where required and with arrangements to be reviewed following implementation.

6. Better Workforce

6.1 Reduced Working Week

The Forum received a verbal update on progress towards implementation of the Reduced Working Week, presented by Kevin Reith, Director of People. It was noted that work was moving into the implementation phase and that arrangements must align with national guidance while maintaining service delivery, staff wellbeing and financial sustainability. It was highlighted that services operate different roster patterns and that while wholesale roster redesign was not intended, some adjustments may be required to support safe and consistent application.

The Forum noted concerns regarding the absence of a written paper at this stage and the risk of inconsistent local approaches given the proximity of implementation. Members emphasised the need for clear governance, adherence to national guidance (particularly for longer roster periods) and robust oversight. The importance of clear, joint communications to managers and staff was highlighted, alongside the need to manage financial implications carefully and ensure implementation was equitable and audit-proof.

The Forum noted the verbal update and agreed that further work was required prior to implementation, including the development of joint communications, establishment of weekly implementation oversight, and submission of a clear paper to APF for assurance, that would set out principles, governance and implementation arrangements. **Action: Kevin Reith**

6.2 NHS Forth Valley Long Service Awards

The Forum received a presentation from Linda Robertson, HR Managers, Staff Governance, who outlined proposals to reinstate NHS Forth Valley Long Service Awards. It was noted that formal ceremonies recognising 20, 30, 40 and 50 years' service had not taken place since May 2023, pending work associated with the *Invest and Celebrate* programme. Linda Robertson advised that there had been increasing requests from staff and managers for the awards to resume. The proposed approach was to reintroduce the awards during 2026, potentially through two events to address the backlog, with recognition including certificates, pin badges and an afternoon tea. It was explained that a hybrid approach would be taken to identifying eligible staff, combining invitations based on system data with an option for staff to self-identify where service history may not be fully captured. Indicative timings of August or September 2026 were suggested, with modest associated costs.

During discussion, members sought clarification on the cost implications of reinstating Staff Awards and emphasised the need to ensure value for money. The potential for external sponsorship was raised, subject to appropriate ethical considerations, as a means of mitigating costs. A question was also raised regarding the use of a professional photographer, with members suggesting that internal communications resources could be utilised where appropriate. Overall, the Forum was supportive of the proposals and recognised the importance of formally acknowledging long service, while noting the need for proportionate and cost-effective arrangements.

7. Better Value

7.1 Finance Report

The Forum received a Finance Report presented by Scott Urquhart, Director of Finance, who provided a verbal update on the Board's financial position. Detail was provided around the scale of the financial challenge at the start of the financial year, the actions taken through the Financial Recovery Plan, and the governance arrangements in place, including oversight via the Financial Stewardship Board. Scott highlighted the collective contribution of services and budget holders in improving financial performance, provided assurance on the projected year-end position and set out the context of national financial pressures affecting NHS Boards. The early planning assumptions for the forthcoming financial year were outlined and the anticipated requirement for continued financial discipline and organisational engagement.

Members welcomed the improved position and sought clarification on the national escalation framework, which was explained as being based on both financial controls and projected performance. The Forum emphasised that financial stewardship was a shared responsibility and noted the scale of the savings challenge anticipated for the next financial year.

The Forum noted the Finance Report and agreed that it provided assurance on the current financial position.

7.2 Value Based Health & Care Collaborative

This item was deferred to a future meeting.

8. For Noting

8.1 Circulars and Policies

The Forum noted the national circulars that had been issued for information. This included ECS MD 2025, relating to changes to management fees for Medical Directors and Associate Medical Directors on pay protection, and PCS AFC 2026/1, which provided information on the Scottish Distant Islands Allowance. Members were advised that no action was required by the Forum in respect of these circulars at this stage.

It was further noted that an additional circular relating to Executive and Senior Manager pay uplift had been received on the day of the meeting and would be circulated to Forum members separately, rather than deferred to the next meeting. **Action: Chair**

8.2 Phase 3 Once for Scotland – update

It was noted that Workforce Policies Phase 3 were expected to be published nationally in early March 2026, prior to the pre-election period. Assurance was provided that the APF would be updated following national publication and confirmation of local implementation arrangements.

8.3 PDP and PLT Update

The Forum received an update from Jenny McCusker, Head of Organisational Development, on progress to strengthen Personal Development Planning (PDP) and Protected Learning Time (PLT) arrangements within NHS Forth Valley. The update focused on improving the quality and consistency of PDP conversations, reinforcing managers' responsibilities to support learning within working time, and enhancing local guidance, tools and communications to support implementation.

During discussion, members sought clarification on how PLT would be recorded consistently across different systems, particularly for services not using e-rostering, and noted the need for pragmatic and proportionate local approaches. The importance of simplifying processes to support meaningful development conversations, rather than a compliance-focused approach, was emphasised. Good practice within Pharmacy was highlighted, and links were made to job evaluation, with members noting the importance of regularly reviewing job descriptions as part of the PDP process.

The Forum noted the update and supported the continued development and implementation of improved PDP and PLT arrangements, with assurance to be provided through routine reporting to Staff Governance.

9. Any Other Competent Business

The Chair raised the requirement to review and update the Partnership Agreement, and it was agreed that this would be captured on the Action Log for progression.

10. Date of next meeting

The next meeting would be held on Tuesday 21 April 2026 at 2 pm

(Post meeting note: meeting date changed to 14 April 2026)

Clackmannanshire & Stirling Integration Joint Board

Minute of IJB Meeting held on 28 January 2026

Approved for Submission by	Dr Jennifer Borthwick, Interim Chief Officer
Paper presented by	N/A
Author	Sandra Comrie, IJB Support Officer
Exempt Report	No

Minute of the **Clackmannanshire & Stirling Integration Joint Board meeting** held on **Wednesday 28 January 2026 in the Boardroom, Carseview House, Stirling and hybrid via MS Teams**

PRESENT

Voting Members
Councillor Scott Farmer **(Chair),** Stirling Council
Allan Rennie (**Vice Chair),** Non-Executive Board Member, NHS Forth Valley
Councillor Martin Earl, Stirling Council
Councillor Jen Preston, Stirling Council
Councillor Fiona Law, Clackmannanshire Council
Councillor Janine Rennie, Clackmannanshire Council
Councillor Martha Benny, Clackmannanshire Council
John Stuart, Non-Executive Board Member, NHS Forth Valley
Finlay Scott, Non-Executive Board Members, NHS Forth Valley
Stephen McAllister, Non-Executive Board Members, NHS Forth Valley
Martin Fairbairn, Non-Executive Board Member, NHS Forth Valley
Clare McKenzie, Non-Executive Board Member, NHS Forth Valley

Non-Voting Members
Dr Jennifer Borthwick, Interim Chief Officer
Amy McDonald, Interim Chief Finance Officer
Natalie Masterson, Third Sector Representative, Stirling
Andy Witty, Carer Representative, Clackmannanshire
Moira Carmichael, Carer Representative, Stirling
Jennifer Rezendes, Chief Social Work Officer, Stirling
Robert Clark, Employee Director, NHS Forth Valley
Kevin McIntyre, Union Representative, Clackmannanshire
Abigail Robertson, Union Representative, Stirling
Anthea Coulter, Third Sector Representative, Clackmannanshire
Dr Kathleen Brennan, GP Clinical Lead, HSCP
Lorraine Robertson, Chief Nurse HSCP
Mike Evans, Localities Representative
Sharon Robertson, Chief Social Work Officer, Clackmannanshire Council
Eileen Wallace, Service User Representative, Stirling

Standards Officer
Lee Robertson, Senior Manager Legal & Governance and Monitoring Officer Clackmannanshire Council

In Attendance
Wendy Forrest, Head of Strategic Planning and Health Improvement
Ross Cheape, Head of Service, Mental Health & Learning Disability Services
Lyndsey Dunn, Head of Community Health and Care
Sandra Comrie, IJB Support Officer (minutes)

1. WELCOME AND APOLOGIES

Councillor Farmer formally welcomed Amy McDonald, interim Chief Finance Officer and Councillor Jen Preston of Stirling Council, who will be succeeding Councillor Rosemary Fraser on the Integration Joint Board (IJB). He extended his appreciation to Councillor Rosemary Fraser for her valuable contributions to both the IJB and Committees.

Apologies for absence were noted on behalf of:

Helen McGuire, Service User Representative, Clackmannanshire
Andrew Murray, Medical Director, NHS Forth Valley

2. NOTIFICATION OF SUBSTITUTES

None

3. DECLARATIONS OF INTEREST

None

3.a ITEMS OF URGENT BUSINESS

Concerns were noted regarding the late submission of the Finance Report and the 2024/25 Audited Annual Accounts and Annual Audit Report. Councillor Farmer clarified that, since the Finance Report had already been addressed earlier in the Integration Joint Board (IJB) development session, its inclusion on the agenda was appropriate. As the 2024/25 Audited Annual Accounts and Annual Audit Report were received by the Board after 5 pm on 27 January 2026, the Chair proposed deferring this item to the special IJB meeting scheduled for 27 February 2026. The postponement allows the Board enough time for a thorough review of the accounts and confidence in the audit results. The Board approved this recommendation.

4. DRAFT MINUTE OF MEETING HELD ON 18 November 2025

The draft minute of the meeting held on 18 November 2025 was approved.

5. ACTION LOG

The action log of the meeting held on 18 November 2025 was approved.

6. CHIEF OFFICER UPDATE

Dr Borthwick delivered a verbal update to the IJB.

Dr Borthwick provided a recruitment update, confirming her role as interim Chief Officer until 31 March 2026. Dr Susie Porteous has been appointed interim Director of Psychological Therapies and the vacancy for the interim Director of Mental Health and Learning Disabilities is expected to be filled soon.
Dr Borthwick welcomed Amy McDonald as interim Chief Finance Officer until 30 June 2026, noting that interviews for the permanent role will be held on 12 February 2026. She also welcomed Lyndsey Dunn, the new Head of Community Health and Care.

The presentation of the “Commissioning Change to the Model of Bed Based Respite in Clackmannanshire and Stirling” paper was postponed to a later meeting, as Dr Borthwick and the interim Chief Finance Officer decided that further financial analysis was required. The IJB Chair and Vice Chair supported the decision. Regular discussions with staff from Ludgate House, Human Resources, and Trade Union representatives have taken place to maintain clear communication about the changes. Dr Borthwick also intends to meet with both the Leader and Chief Executive of Clackmannanshire Council.

Dr Borthwick stated that the Mental Health Unit at Forth Valley Royal underwent an unannounced Healthcare Improvement Scotland (HIS) inspection in August 2025. The inspection’s final report was released on 28 January 2026 and distributed to IJB members. Dr Borthwick summarised the main concerns and issues from the report as well as the planned steps for improvement.

Due to significant financial challenges and to provide sufficient opportunity for the IJB to review, discuss, and actively participate in decision-making, a special IJB meeting has been arranged for 27 February 2026. Following a discussion with Dr Borthwick, the Chair and Vice Chair of the Finance, Audit and Performance (FAP) Committee agreed that the meeting scheduled for 18 February 2026 can be limited to 1.5 hours, followed by a budget development session on the same day. This will allow IJB members additional time for discussion prior to the special meeting on 27 February 2026.

Ms McKenzie requested a separate document illustrating how the HIS inspection improvement work is reported to the IJB for accountability.

7. FINANCE UPDATE

The IJB considered the paper presented by Amy McDonald, Interim Chief Finance Officer

Ms McDonald stated the report provides an update on the year-end financial forecast, with a projected deficit of approximately £15.5 million. Efforts will focus on reducing this figure over the coming months by evaluating earmarked balances for possible offsets. Releasing reserves would lower the forecasted deficit to just over £7 million. Ms McDonald has yet to review the 2026/27 savings plans in detail.

Councillor Law raised the question of reaching out to the Scottish Government regarding the possibility of receiving budgets for extended periods. Ms McDonald will continue to discuss the IJB financial pressures through the Chief Finance Officer network meeting who collectively raise concerns around funding to Scottish Government. An update will be provided at a future IJB meeting.

Mr Fairbairn highlighted the potential risks associated with interim senior leadership roles. He also proposed that the IJB commissions Dr Borthwick and Ms McDonald to engage closely with the constituent authority Chief Executives to develop draft improvement strategies, focusing on the commitment from the constituent authorities to deliver these and the support they think the IJB and HSCP needs to do this. The Board agreed that this proposal should be incorporated into the recommendations.

Councillor Earl questioned how much of the earmarked reserves is available, why it wasn't used sooner to offset the deficit, and whether some should be retained. Ms McDonald explained that the reserves would likely be used this year or next, but older balances must be reviewed for usage. She noted the importance of rebuilding reserve levels over the coming years. Councillor Law requested that elected members receive regular updates on the reserve status and delivery plan progress.

The Integration Joint Board:

1) **Noted the financial position as at 30 November 2025 for the 2025/26 integrated budgets;**
2) **Noted the challenging factors that have caused the Interim Chief Finance Officer to re-evaluate the financial implications for the deliverability of the IJB 2025/26 Delivery Plan, that means a substantial overspend for the year is now forecast;**
3) **Noted the potential for use of IJB ear marked reserves no longer fully committed, up to the draft value of £8.201m, utilising all available reserves thus leaving no contingency to manage budget fluctuations in future years;**
4) **Noted the forecast 2025/26 deficit position of £7.295m after the use of up to £8.201m from reserves;**
5) **Noted the Interim Chief Finance Officer has notified partners of the financial deficit forecast for the year. Any financial deficit will be managed through the terms of the Integration Scheme;**
6) **In light of the latest forecast for the current financial year, noted work to date to refresh the draft forecast budget position for**

2026/27, that has indicated an emerging gap in funding of circa £21.190m;

7) **Noted, that at this stage, similar to the November 2025 delivery plan, there are key areas of the budget that will have to be tackled to bring costs in line with total funding. Indicative areas and changes which could be made, are:**
   - **Eligibility criteria for service users;**
   - **Delivery of services to meet statutory requirements;**
   - **Consideration of sustainability of additional services currently provided to service users;**
   - **Work to bring efficiencies to the partnership which will bring financial sustainability in future years;**
   - **Consider and mitigate the risk associated with all budget savings plans changing services levels to meet financial expenditure limits.**
8) **Acknowledged a significant effort will be required to deliver in year savings of over £20m in 2026/27, that these will not be without a wide range of implications and therefore there remains a risk that a deficit in 2026/27 may emerge.**
9) **Noted that the Interim Chief Officer and Interim Chief Finance Officer take an active role in the respective Chief Officer HSCP Network and Chief Finance Officer HSCP Network groups in putting forward the case for greater financial support for Health and Social Care services.**
10) **Commissions the Interim Chief Officer and Interim Chief Finance Officer to engage closely with the Constituent Authority CEOs on:**
   - **our draft improvement strategies;**
   - **their commitment to deliver these improvement strategies as the Constituent Authorities; and**
   - **the support they think the IJB and HSCP needs to deliver the improvement strategies.**

8. 2024/25 AUDITED ANNUAL ACCOUNTS AND ANNUAL AUDIT REPORT

As discussed at item 3a Urgent Items of Business, the Board agreed that the paper is deferred to the special IJB meeting on 27 February 2026.

9. STIRLING CHIEF SOCIAL WORK OFFICER REPORT 2024/25

The IJB considered the paper presented by Jennifer Rezendes, Chief Social Work Officer

Ms Rezendes presented the Chief Social Work Officer's annual report, which is submitted to the Scottish Government, IJB, and Stirling Council. The report aims to provide assurance regarding the quality, safety, and effectiveness of statutory social work services. She emphasised that the report fulfils legal requirements by outlining professional leadership, service performance, and

notable advancements in the care and protection of vulnerable populations. The report, covering the 2024/25 period, features data from HSCP delegated services to facilitate comprehensive analysis.

Ms Rezendes thanked social work staff for their daily commitment, pointing out that this dedication is evident in the results of the report. She also recognised the former Chief Social Work Officers who served up to December 2024. Additionally, she outlined the key successes and challenges mentioned in the report, highlighting that collaboration and teamwork are central themes across all areas of social work practice discussed.

Ms Rezendes noted that increasing demands for social work and care services are creating significant strain across the sector, complicating efforts to fulfil statutory requirements. She identified financial constraints, heightened demand, and intricate cases as principal issues facing adult social work. Ms Rezendes presented her recommendations for the next three months.

Mr Witty asked about the existing plans and approach for Self-directed Support (SDS) options and mentioned he would like the report to acknowledge the contributions of unpaid carers. Ms Rezendes responded that an SDS paper had been presented at the professional Chief Social Work Officer Governance meeting, where she requested clarification on why option 3 was preferred, as it wasn't clear if all four options were considered. She also agreed that the report should contain more details about carers.

Ms Rezendes confirmed that the next reporting cycle will start in February for development of the CSWO Report, her office will request information from the HSCP to help her perform her analysis and form an opinion through established procedures. Ms Rezendes has provided the HSCP with a professional assurance framework that highlights key areas where relevant information can be contributed. The framework is designed to help both her and the interim Chief Officer gain joint confidence about actions for improvement or to acknowledge good practice. Ms Forrest and Ms Rezendes discussed options concerning the Carers Planning Group and SDS Steering Group, deciding to schedule a meeting to enable them to identify the best resources for analysing this work so it can be included in the upcoming report.

The Integration Joint Board:

1) **Considered and took assurance from the Chief Social Work Officer's Annual Report.**
2) **Noted that the Chief Social Work Officer’s report has been submitted to Scottish Government.**

10. CLACKMANNANSHIRE CHIEF SOCIAL WORK OFFICER REPORT 2024/25

The IJB considered the paper presented by Sharon Robertson, Chief Social Work Officer

As Ms Rezendes had provided a comprehensive overview of governance matters and the statutory requirements pertaining to the Chief Social Work Officer reports, Ms Robertson provided an overview of activity and performance within Clackmannanshire Council and the HSCP. She addressed notable achievements, ongoing challenges, emerging initiatives, and underscored the significance of collaborative family support. Following discussion, she addressed questions on self-directed support, carers, complaints, and youth justice. Ms Robertson also expressed her sincere appreciation to both staff members and unpaid carers for their valuable contributions.

Following discussion, it was agreed that Ms Forrest and Mr Witty would meet to discuss how HSCP officers can better communicate the outcomes of assessments with those being assessed.

Dr Borthwick replied to Mr Scott's question about complaints data by noting efforts are underway to streamline the HSCP complaints process and allow for easier identification of key themes.

The Integration Joint Board:

1) Noted the Chief Social Work Officers' Annual Report.

11. REVIEWING THE STRATEGIC COMMISSIONING PLAN - UPDATE

The IJB considered the paper presented by Wendy Forrest, Head of Strategic Planning and Health Improvement.

The paper summarised the results of engagement sessions and on-line survey held with communities, staff, people with lived experience and the broader system regarding the strategic commissioning plan's review process. The three-year review will not be a rewrite of the plan as it is an already agreed ten-year plan but rather an opportunity to reflect and refresh the prioritisation of activity. Ms Forrest confirmed that the paper aligns with the standard three-year review process and presents the findings from engagements.

Ms Forrest provided a comprehensive summary of both the feedback received and the areas identified for further attention, aligning these with ongoing financial initiatives. She will prepare a paper detailing the recommended focus areas for inclusion in an updated and refreshed plan, which is scheduled to be presented at the IJB meeting on 25 March 2026.

The Integration Joint Board:

1) **Considered and noted the progress for reviewing the Strategic Commissioning Plan 2023 - 2033.**
2) **Noted the engagement process undertaken across the whole system.**
3) **Noted and approved the proposed areas for inclusion derived from the consultation process, noting that they are in alignment with the Delivery Plan.**

12. STRATEGIC RISK REGISTER

The IJB considered a paper presented by Ross Cheape, Head of Service, Mental Health and Learning Disability Services

Mr Cheape explained there are no significant changes to the Strategic Risk Register (SRR) and the purpose of the paper was to confirm that the SRR has moved to the NHS Forth Valley Risk Management system and work is being carried out to show the progress against each of the strategic risks.

The SRR will be submitted to the Finance, Audit and Performance Committee on 03 June 2026 with updated risk assessments, prior to presentation at the IJB meeting on 24 June 2026. To ensure the Board has a comprehensive understanding of the underlying strategic risks, he recommended holding a development session focused on risk before the IJB meeting on 24 June 2026.

There are currently 13 risks 3 of which are rated red, which are mainly linked to the financial position and the strategic direction. Following discussion Mr Cheape and Ms McDonald acknowledged the need for greater transparency, more frequent updates, and accelerated work on risk profiling, especially given financial challenges.

The Board recommended that Mr Cheape refrain from duplicating work across both systems during the transition period.

The Board requested a revised SRR timeline. Mr Cheape committed to presenting an updated SRR, including legacy data, clearer risk matrix wording, and better social care risk coverage, at the 25 March 2026 IJB meeting, bringing it forward from 24 June 2026. He also suggested holding the risk development session before the IJB meeting on 25 March 2026.

The Integration Joint Board:

1) **Noted the alterations to the management of the Strategic Risk Register**
2) **Noted the new format for risk Reporting**

3) **Approved the proposal to have a development session on Risk and Risk Management**

13. FOR NOTING

a. Minute - Strategic Planning Group 10 September 2025
b. Minute - Joint Staff Forum 21 August 2025

14. ANY OTHER COMPETENT BUSINESS (AOCB)

None

15. DATE OF NEXT MEETING

25 March 2026

Minute of the **Clackmannanshire & Stirling Integration Joint Board special meeting** held on **Friday 27 February 2026 2 pm – 3.30 pm via Teams**

PRESENT

Voting Members

Councillor Scott Farmer (Chair), Stirling Council
Allan Rennie (Vice Chair), Non-Executive Board Member, NHS Forth Valley
Councillor Janine Rennie, Clackmannanshire Council
Councillor Fiona Law, Clackmannanshire Council
Councillor Martha Benny, Clackmannanshire Council
Councillor Martin Earl, Stirling Council
Councillor Jen Preston, Stirling Council
John Stuart, Non-Executive Board Member, NHS Forth Valley
Finlay Scott, Non-Executive Board Member, NHS Forth Valley
Stephen McAllister, Non-Executive Board Member, NHS Forth Valley
Martin Fairbairn, Non-Executive Board Member, NHS Forth Valley
Clare McKenzie, Non-Executive Board Member, NHS Forth Valley

Non-Voting Members
Dr Jennifer Borthwick, Interim Chief Officer
Amy McDonald, Interim Chief Finance Officer
Kevin McIntyre, Union Representative, Clackmannanshire
Jennifer Rezendes, Chief Social Work Officer, Stirling Council
Natalie Masterson, Third Sector Representative, Stirling
Anthea Coulter, Third Sector Representative, Clackmannanshire
Abigail Robertson, Union Representative, Stirling
Dr Kathleen Brennan, GP Clinical Lead, HSCP
Lorraine Robertson, Chief Nurse HSCP
Andy Witty, Carer Representative, Clackmannanshire

Standards Officer
Lee Robertson, Senior Manager Legal & Governance and Monitoring Officer
Clackmannanshire Council

In Attendance
Stuart Kenny, Director, Deloitte LLP
Wendy Forrest, Head of Strategic Planning and Health Improvement
Lyndsey Dunn, Head of Community Health and Care
Nikki Bridle, Chief Executive, Clackmannanshire Council
Sandra Comrie, IJB Support Officer (minutes)

1. APOLOGIES FOR ABSENCE

Apologies for absence were noted on behalf of:

Andrew Murray, Medical Director, NHS Forth Valley
Helen McGuire, Service User Representative, Clackmannanshire
Eileen Wallace, Service User Representative, Stirling
Sharon Robertson, Chief Social Work Officer, Clackmannanshire Council
Mike Evans, Localities Representative
Moira Carmichael, Carer Representative, Stirling

2. NOTIFICATION OF SUBSTITUTES

None

3. DECLARATIONS OF INTEREST

None

4. 2024/25 AUDITED ANNUAL ACCOUNTS AND ANNUAL AUDIT REPORT

Paper presented by Amy McDonald, Interim Chief Finance Officer.

Ms McDonald provided an update on the accounts, explaining that their finalisation had taken longer than anticipated. This resulted in them not being able to be presented as planned at the Integration Joint Board (IJB) meeting on 28 January 2026.

Mr Kenny presented the audit report, stating that, subject to receipt of the signed representation letter and signed accounts, Deloitte would issue an unmodified audit opinion, which is equivalent to a clean audit opinion. He noted that the paper was consistent with the draft version presented to the Finance, Audit and Performance Committee on 14 January 2026, except for two areas: the resolution of outstanding matters and the identification of an immaterial unadjusted misstatement.

Mr Kenny explained the representation letter, highlighted the issue of the gap in having a formal Section 95 officer in place in late 2025 and noted that this issue was also detailed in the ISA 260 report. He confirmed that the unadjusted misstatement identified during the audit was immaterial and did not impact the audit opinion.

Mr Fairbairn asked for clarification regarding a discrepancy between the detailed transaction listing and the accounts. Mr Kenny explained that the complexity arose from combining three sets of transactional information, which can lead to

potential differences. Ms McDonald confirmed that she had worked closely with Deloitte to resolve the issue and was satisfied with the outcome.

Mr Scott raised questions about the wording in the governance statement regarding the inability to set a deliverable balanced budget for 2025-26. Ms McDonald explained that the Board had not yet been able to set a balanced budget for 2025-26 and that work was ongoing to address this.

Mr Witty asked about the implications of operating without a Section 95 officer for two months. Dr Borthwick responded that Audit Scotland was conducting a report on this issue, and the Board was awaiting its outcome.

Mr Fairbairn requested clarification on a £3.5 million movement in the accounts and the treatment of an additional payment from Clackmannanshire Council. Ms McDonald explained that the difference was due to the NHS's additional contribution, which was held in reserves for use in 2025-26. Ms McDonald further clarified that Clackmannanshire Council had provided additional resources under the integration agreement, which permitted such contributions, this contribution was not a loan.

Councillor Earl questioned whether the integration scheme's risk share section permitted such contributions in the absence of an agreed risk share protocol. Ms McDonald confirmed that the integration agreement allowed partners to provide additional resources, and Ms Bridle clarified the distinction between a repayable contribution and a loan.

Mr Scott requested clarity on the completion of action plans in the accounts. Ms McDonald confirmed that some actions were incomplete and that additional narrative was included in the Audit Report on the external audit actions.

The Integration Joint Board:

1) **Considered and agreed the Integration Joint Board's 2024/25 Audited Accounts for signature, as attached at Appendix A.**
2) **Instructed the Interim Chief Finance Officer to submit the approved audited accounts to NHS Forth Valley, Stirling Council and Clackmannanshire Council.**
3) **Instructed the Interim Chief Officer to sign the representation letter, as attached at Appendix B.**
4) **Considered the External Auditor's Annual Audit Report and noted the recommendations and management comments in the Report Action Plan, as attached at Appendix C. Progress will be monitored through the Finance, Audit and Performance Committee.**

5. FINANCE REPORT

Paper presented by Amy McDonald, Interim Chief Finance Officer.

Ms McDonald presented the finance report, highlighting the overspend for 2024-25, the use of reserves, and the need for partner contributions. She explained that the inability to balance the 2025-26 budget was due to strategic drift, and that improved governance and savings delivery were required.

Mr Witty emphasised the importance of maintaining a preventative agenda and balancing financial efficiency with support for vulnerable individuals. He expressed concern that short-term financial pressures could undermine long-term resilience and the support provided to unpaid carers.

Mr Fairbairn noted that the financial position was unacceptable and that the Board must focus on achieving a balanced budget. He suggested that the Board formally acknowledge the concerning outturn for 2025-26 and commit to avoiding such outcomes in the future.

Mr Rennie asked about the prevailing risk share arrangements. Ms McDonald explained that the arrangements could be reviewed annually and could change depending on the approach agreed by partners.

Dr Borthwick assured the Board that strong clinical and care voices were included in planning, with input from the senior leadership team and engagement with people with lived experience and carers.

Councillor Law requested more detailed meetings and member briefings for planned savings and service changes, to ensure informed decision-making.

Councillor Earl welcomed the candour regarding strategic drift but questioned whether all planned savings could have been achieved. He highlighted the challenge of balancing the budget and maintaining service delivery, noting that necessary service reductions might be required.

Ms McKenzie asked whether the IJB was disproportionately challenged compared to other Integration Joint Boards. Ms McDonald responded that the financial challenge was significant but not unique, with similar pressures across Scotland. Mr Rennie referenced an Audit Commission report indicating a collective shortfall across IJBs which he would share with the Board.

Councillor Earl requested a full breakdown of earmarked reserves to be repurposed. Ms McDonald agreed to provide this information, explaining that funds for projects not started or fully committed would be released to support the year-end position.

Mr Fairbairn asked about Board engagement before the next IJB meeting. Ms McDonald stated that she would coordinate dates with Sandra Comrie for an additional IJB member session prior to the IJB meeting on 25 March 2026.

The Integration Joint Board:

1) **Noted the forecast financial position at 31 March 2026 for the 2025/26 integrated budgets;**
2) **Noted that the substantial overspend for the year is forecast at £15.496m, before approval to release up to £4.201m of ear marked reserves and use of general reserves of £4m;**
3) **Instructed the Interim Chief Officer to write to NHS Forth Valley, Clackmannanshire Council and Stirling Council to request an additional one-off payment to the IJB to meet the 2025/26 overspend in accordance with the Integration Scheme and preferred risk share arrangements of partners;**
4) **Acknowledged that significant work is being undertaken to refresh the draft forecast budget position for 2026/27, which will involve addressing further pressures as they come forward; and**
5) **Noted that a significant effort will be required to deliver in year savings with work to structure a robust delivery plan around this underway.**

Close of Meeting

Clackmannanshire & Stirling
Health & Social Care Partnership

Clackmannanshire & Stirling HSCP
Stirling Health & Care Village
Outpatients Dept, OPD Area 2
Livilands Gate
Stirling
FK8 2AU
Date: 21 April 2026
Ref: JB/SC
Email: jennifer.borthwick@nhs.scot

Ross McGuffie
Chief Executive
NHS Forth Valley
Carseview House
Castle Business Park
Stirling
FK9 4SW

Dear Ross

Clackmannanshire & Stirling Integration Joint Board – Initial Direction to NHS Forth Valley 2025-26

The Clackmannanshire and Stirling Integration Joint Board, at its meeting on 25 March 2026 considered the following paper:

- Annual Budget Report 2026/27

The full suite of papers is available here IJB-Wednesday-25-March-2026.pdf

The recommendation to issue a Direction to NHS Forth Valley for implementation was unanimously approved and the details of the Direction are included at the end of the appended report and attached.

I trust this is satisfactory,

Yours sincerely

A. McDonald

Amy McDonald

Pp Dr Jennifer Borthwick
Interim Chief Officer
Clackmannanshire & Stirling Health & Social Care Partnership

Enc

Clackmannanshire Council
Stirling Council
NHS Forth Valley

Reference Number: CSIJB-2025_26/021

Direction – Forth Valley Health Board

DIRECTION ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

Forth Valley Health Board is hereby directed to deliver for the Board, the services noted below in pursuance of the functions noted below and within the associated budget noted below. Services will be provided in line with the Board's Strategic Plan, directions previously issued by the integration joint board and existing operational arrangements pending future directions from the Board.

Approval from IJB received on: 25 March 2026
Description of services/functions:- All community health services covered by the Clackmannanshire and Stirling Integration Scheme.

Reference to the integration scheme:- All services listed in Annex 1, Part 1 and appropriate services listed in Part 2 of the Clackmannanshire and Stirling Health and Social Care Integration Scheme.

Link to strategic priorities (with reference to strategic plan and commissioning plan):

1. Prevention, early intervention and harm reduction
2. Independent Living through choice and control
3. Achieving Care Closer to Home
4. Supporting empowered people and communities
5. Reducing loneliness and isolation

Timescales involved:-
Start date: 01 April 2026
End date: 31 March 2027

Associated Budget:
The associated budget for these functions and services is £204.768m.

This direction is effective from 1 April 2026.

Link to relevant IJB report(s) IJB-Wednesday-25-March-2026.pdf

Minute of hybrid meeting of the Integration Joint Board held within **Grangemouth Community Education Unit, 69-71 Abbots Road, Grangemouth, FK3 8JB** and **remotely** on **Friday 30 January 2026** at **9.30 a.m.**

Voting Members:	Councillor Fiona Collie Councillor Jim Flynn Councillor Anne Hannah Gordon Johnston (Chair) Stephen McAllister
Non –voting Members:	Marie Keirs, Chief Finance Officer (Items IJB68, IJB69 & IJB72) Sara Lacey, Chief Social Work Officer (Item IJB70) Amanda Winters, Carer Representative (Substitute) David McNiven, Service User Representative Lynsey Hansford, Third Sector Interface (Substitute) Roger Ridley, Staff Representative, Falkirk Council Gail Woodcock, Chief Officer (Item IJB67)
Also Attending:	Tom Cowan, Head of Strategic Planning & Transformation Caroline Doherty, Head of Community Services Jim Millar, Team Leader – Committee Services Ewan Murray, Business & Governance Lead Paul Surgenor, Communications Officer (Item IJB71) Suzanne Thomson, Commissioning Lead (Item IJB74) Carly Toland, Committee Officer Cheryl White, Falkirk HSCP Support Officer Nicola Wood, Chief Nurse

IJB63. Apologies

Apologies were submitted on behalf of Victoria McRae.

Amanda Winters was attending as a substitute for Sharon Mwale.

Lynsey Hansford was attending as a substitute for Victoria McRae.

IJB64. Declarations of Interest

There were no declarations of interest.

IJB65. Minute

Decision

The Integration Joint Board approved the minute of the meeting held on 5 December 2025.

IJB66. Action Log

An action log detailing ongoing and closed actions following the previous meeting on 5 December 2025 was provided.

Items IJB55 was the subject of a report on the agenda and subsequently fell as a closed action on the rolling action log.

Decision

The Integration Joint Board noted the Action Log.

Stephen McAllister joined the meeting during consideration of the following item.

IJB67. Chief Officer Report

The Board considered a report by the Chief Officer highlighting current developments locally, regionally, and nationally which were likely to be of interest to Board members.

The Board requested that the Care Inspectorate – Care at Home report referred to within the report is circulated to all Board members following the meeting.

The Board asked for further information regarding GP walk-in centres. The Head of Strategic Planning & Transformation advised that the centres were aimed at improving same-day access to urgent primary care. Following a question around how these would be staffed, the Head of Strategic Planning & Transformation acknowledged that the flexible set up of walk-in centres may be attractive to clinicians, including GP's, in terms of recruitment. However, he noted that while there was evidence of the availability of GPs, the challenge was ensuring sustainable funding to attract them to local positions.

The Board asked about the Scottish Statutory Instrument to extend voting rights to IJB Lived Experience representatives. The Chief Officer advised that this was still going though formal processes and conversations were taking place at a national level to map this out. She noted that ensuring the voices of those with lived experience were heard, and that the right support was in place, was paramount in IJB decision-making. She added that more information about this change would come forward for consideration in due course.

The Board asked for an update on the approval of the revised Integration Scheme. The Chief Officer advised that this was now with Scottish Government ministers, and a response was expected soon. She noted that she had spoken to the Council's Chief Governance Officer around the implications of the Scottish Statutory Instrument on the approval of the Integration Scheme, and advised that any change arising from this would likely require revisions to the IJB Standing Orders.

The Board asked about support for carers as a result of the Care at Home inspection report. The Head of Community Services advised that the strategic aim and delivery of support for carers had been highlighted as an area for improvement. She noted that there was ongoing work to ensure carers had the right support at the right time.

The Board asked for further information on changes to the Care Opinion platform. The Chief Officer advised that people could still share their experiences through Care Opinion, and the only change was that a fewer number of staff would now manage responses in order to achieve better value for money. The Communications Officer provided assurance that there were multiple channels available for people to submit their opinions, including through the NHS Forth Valley's and Falkirk Council's own feedback mechanisms and through direct feedback to services.

Decision

The Integration Joint Board:-

(1) noted the report, and

(2) approved the appointment of Iain Dickson as 3rd sector representative to the IJB and the IJB Performance, Audit and Assurance Committee for a 3-year period commencing immediately.

IJB68. 2026/27 Business Case and Medium-Term Financial Plan Update

The Board considered a report by the Chief Finance Officer which provided an updated position to the IJB on the budget pressures and assumed funding for the 2026/27 Revenue Budget and the 5-year medium-term financial plan (MTFP) to 2030/31.

The Chief Finance Officer advised that an amended version of Appendix 3 to the report had been circulated to all members prior to the meeting. This detailed additional information in relation to charging for use of services in Thornton Gardens for other local authorities at £2,985.57 per week.

The Board asked for further information about the settlement from the Scottish Government. The Chief Finance Officer advised that the funding

included in the assumptions was in relation to Living Wage uplift and the Free Personal and Nursing Care uplift. She noted that the funding for the Scottish Living Wage uplift did not cover the IJB's liability of £6m, which meant there was £1.4m shortfall. Following a question around this shortfall, the Chief Finance Officer advised that the settlement provided no additionality (extra care packages/placements).

Following a question around consultation in the Braes, the Chief Finance Officer advised that she would liaise with engagement staff to try and arrange a session in that area.

The Board asked about the scale of risk in relation to job evaluations. The Chief Finance Officer advised that all of the required information was not yet available, but indicative figures showed that the financial risk could potentially range between £140k to over £1m.

The Board asked for an update on Dementia Services. The Chief Finance Officer advised that funding had been set aside for 8 pillar support and it was available for use and recommendations would come forward to SLT.

Decision

The Integration Joint Board:-

(1) noted the funding pressures set out in the paper, and risks identified at Section 5 of the report, and the actions required and carried out to date to bring forward the 2026/27 business case and MTFP;

(2) approved the recommended payments for 2026/27 in relation to Partnership Funds with our third and independent sector providers shown in Appendix 5 of the report;

(3) endorsed the charging proposals set out in the amended version of Appendix 3 of the report, which included additional information in relation to charging for use of services in Thornton Gardens for other local authorities at £2,985.57 per week, for remitting to Falkirk Council for approval along with the Council's budget on 5 March 2026, charging not being delegated to the IJB, and

(4) noted the approach for the Care at Home redesign and Bedded Care Reviews set out in paragraphs 4.24 to 4.27 of the report.

IJB69. Budget Monitoring Report January 2025/26

The Board considered a report by the Chief Finance Officer which presented a high-level summary of the current 2025/26 projected financial position including consideration of risks to the financial position.

The Board asked about the Council's share of additional funding required during this financial year. The Chief Finance Officer advised that the recognised risk share arrangements by the IJB's partners was £4.5m and the Council's share of this was £2.592m. She noted that it was anticipated that the full amount of risk share arrangements would be required for this financial year and contingency reserves would be used to cover the remaining shortfall.

Following a question around the Shifting the Balance of Care project, the Chief Finance Officer advised that a business case for recurring funding was being finalised and would be subject to approval by Health Board.

Decision

The Integration Joint Board:-

(1) noted the current projected position for integrated budgets and set aside services;

(2) noted the non-recurring reserves position set out in Appendix 5 of the report, and

(3) authorised the Chief Officer to issue revised Directions to Falkirk Council and NHS Forth Valley as per the Directions provided at Appendix 6 of the report.

The Board adjourned at 10:40am and reconvened at 10:55am.

IJB70. Chief Social Work Officer Annual Report

The Board considered a report by the Chief Social Work Officer (CSWO) which provided an overview of how the statutory responsibilities of the CSWO had been fulfilled during 2024/25, as well as an overview of the work undertaken by social work services and the achievements recognised during this period.

The Board asked about challenges in recruitment and retention. The CSWO advised that had been a theme for several years, and there was a national challenge around the retention of social workers and occupational therapists. She explained that a working group met regularly to discuss opportunities for improvement, including exit interviews, student placements and improved career progression pathways. She noted that it was important to understand the reasons why staff were leaving the profession in order to improve retention.

The Board asked about early intervention and prevention. The CSWO advised that this looked different for every individual, but the service prioritised the right interventions at the right time in order to reduce escalation.

The Board asked about the establishment of a Bairns' Hoose. The CSWO advised that a strategic group met regularly to discuss the development of this, in addition to the Chief Officers Group for Public Protection.

The Board asked for further information on the number of children on the child protection register. The CSWO advised that understanding the governance of child protection data was an important factor in this, as high or low numbers did not necessarily indicate a particular trend. She explained that this was closely monitored by the Child Protection Committee, who were supported by an improvement group who analysed the data in order to target service gaps.

The Board asked about the reduction in recurring budgets and impact of this on the third sector and its service users. The CSWO advised that there may be an impact, however the Equality and Poverty Impact Assessment process was key in ensuring mitigating actions could be identified for impacted groups.

Following a question around kinship care arrangements, the CSWO advised that there were frequent kinship care support groups which were well attended and well supported.

Decision

The Integration Joint Board:-

(1) noted the report, and

(2) acknowledged the commitment, skills and experience of social work staff in continuing to deliver services in challenging circumstances.

IJB71. Communications & Engagement Update

The Board considered a report by the Communication Lead and Policy & Research Officer which provided a summary of communications and engagement activity undertaken during October - December 2025.

Decision

The Integration Joint Board noted the report.

IJB72. Assurance Report from Performance, Audit and Assurance Committee 16 January 2026

The Board considered a report by the Chief Finance Officer which sought to provide assurance to the IJB on the items considered at the Performance Audit & Assurance Committee (PAAC) held on 16 January 2026.

Decision

The Integration Joint Board noted the Assurance Report produced following the PAAC on 16 January 2026 at Appendix 1

IJB73. Exclusion of Public

The Board agreed to exclude the public during consideration of the following item of business in terms of Standing Order 11(1), Appendix 1 (viii, ix, x), of its Standing Orders on the grounds that the item would include information relating to the financial or business affairs of another person.

The Board adjourned at 11:35am and reconvened at 11:40am.

IJB74. Commissioning and Contracts Monitoring Report

The Board considered a report by the Commissioning Lead which provided a mid-year update on activity from 1 April – 30 November 2025. The report had been developed in collaboration with Falkirk Council Corporate Procurement Team (CPU) and is the first HSCP Commissioning and Contract Monitoring report.

Decision

The Integration Joint Board:-

(1) noted the update included in the report, and

(2) noted the decision by Senior Management Team to exercise a one-year extension to the current Care and Support at Home Framework in line with the original framework agreement.

NHS Forth Valley

Forth Valley NHS Board

8. Strategic Risk Register Update – February ’26-April ’26
Purpose: This report is for Decision

Executive Sponsor: Kerry Mackenzie, Acting Director of Strategic Planning & Performance
Author: Miss Vicky Webb, Head of Risk Management

Executive Summary

The enclosed report presents an update to the Strategic Risk Register for the period of February 2026 to April 2026. The report reflects a point in time as the information held within the report is endorsed by each of the Standing Governance Committees prior to final approval at Board, therefore the timescales indicated within the report reflect the conversations held at those meetings.

Action Required

The Forth Valley NHS Board is asked to:

(1) approve the changes to the Strategic Risk Register for this reporting period (Feb’26-April-26).
(2) note the progression of the mitigating actions identified.
(3) note the update on the focused reviews conducted within this period.
(4) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

This matter has previously been considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Clinical Governance Committee, at every meeting. The committee reviewed the risks within its remit and formally endorsed the existing position to the Forth Valley NHS Board.
- Staff Governance Committee, at every meeting. The committee reviewed the risks within its remit and formally endorsed the existing position to the Forth Valley NHS Board.
- Strategic Planning, Performance & Resources Committee at every meeting. The committee reviewed the risks within its remit and formally endorsed the existing position to the Forth Valley NHS Board.

Risk Assessment and Mitigation

The report details the current Strategic Risk position.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial and Infrastructure Implications

Financial and Infrastructure implications are detailed where relevant to risk.

Workforce Implications

Workforce implications are included in the body of the paper where relevant to risk.

Quality / Patient Care Implications
Patient Harm and Patient Experience implications are included in the body of the paper where relevant to risk.

Population Health & Care Strategy
Our Strategic Risks are risks that will impact on our ability to meet the overall aims of the Population Health & Care Strategy.

Climate Change / Sustainability Implications
Climate Change implications are included in the body of the paper where relevant to risk.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

- If yes, please provide details.

Appendices
Appendix 1 – Strategic Risk Register Update – Feb'26-April-26

Appendix 1 - Strategic Risk Review – February'26-April'26

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1.Summary and Key Messages

All current strategic risks were reviewed during this period and remain unchanged. See section two for more details.

One focused review has been completed in this reporting period, SRR003: Information Governance. This was presented to the Strategic Planning, Performance & Resources Committee in March. The outcome of this is presented in Section 5 of this report.

There is no change to the appetite profile of the Board for this reporting period. As it stands, there are currently 0% of risks within the Boards appetite, 33% are within the Boards tolerance and 67% are out with the Boards appetite and tolerance. Section 4 of the report provides further details on this.

There are no overdue actions to note for this reporting period with 10 actions completed within this reporting period.

2.Strategic Risks in Focus

2.1 Strategic Risk Dashboard

Ref	Risk Title	Untreated Score	Current Score	Date Assessed	Score History	Risk Trend	Target Score	Owned By	Governance Group	Lead Impact Category
SRR 002	Urgent & Unscheduled Care	25	25	10-Mar-2026	25; 25; 25		10	Garry Fraser	Clinical Governance Committee	Patient Harm
SRR 005	Financial Sustainability	25	25	19-Mar-2026	25; 25; 25		15	Scott Urquhart	Strategic Planning, Performance and Resources Committee	Financial
SRR 004	Scheduled Care	20	20	06-Feb-2026	20; 20; 20		10	Garry Fraser	Clinical Governance Committee	Patient Harm
SRR 011	Digital & eHealth - Infrastructure & Strategy	20	20	20-Mar-2026	20; 20; 20		6	Scott Jaffray	Strategic Planning, Performance and Resources Committee	Service Delivery/Business Interruption
SRR 015	Cyber Resilience	25	20	19-Mar-2026	20; 20; 20		16	Andrew Murray	Strategic Planning, Performance and Resources Committee	Service Delivery/Business Interruption
SRR 017	Environmental Sustainability & Climate Change	25	20	02-Mar-2026	20; 20; 20		16	Morag Farquhar	Strategic Planning, Performance and Resources Committee	Environmental Sustainability/ Climate Change
SRR 020	Health Inequalities	25	20	19-Mar-2026	20; 20; 20		10	Jennifer Champion	Strategic Planning, Performance and Resources Committee	Health Inequalities
SRR 009	Workforce Plans	25	15	26-Feb-2026	15; 15; 20		10	Kevin Reith	Staff Governance Committee	Financial
SRR 018	Primary Care Sustainability	20	15	19-Mar-2026	15; 15; 15		10	Gail Woodcock	Strategic Planning, Performance and Resources Committee	Patient Harm
SRR 019	Culture & Leadership	25	15	26-Feb-2026	15; 15; 15		10	Kevin Reith	Staff Governance Committee	Inspection/Audit
SRR 003	Information Governance	20	12	19-Mar-2026	12; 12; 12		8	Andrew Murray	Strategic Planning, Performance and Resources Committee	Inspection/Audit
SRR 010	Estates & Supporting Infrastructure	25	12	02-Mar-2026	12; 12; 12		6	Morag Farquhar	Strategic Planning, Performance and Resources Committee	Service Delivery/Business Interruption

2.2 Strategic Risks in Focus

SRR 002 Urgent & Unscheduled Care		Current Score	Managed By	Assigned To
Risk Description	If we do not have enough whole system capacity and flow to address key areas of improvement, there is a risk that we will be unable to deliver safe, effective, and person-centred unscheduled care resulting in a potential for patient harm, increases in length of stay, placement of patients in unsuitable places, and a negative impact on patient & staff experience.	25	Garry Fraser	Fiona Murray
		Target Score	**Lead Impact Category**	**Appetite Level**
		10	Patient Harm	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		06-Jan-2026		Zero

Latest Update
This risk has been reviewed and there is no change to the current score at this time. Progress has been made against the risk actions being progressed. Additionally, an action has been added around the implementation of the additional capacity of the Hospital at Home beds.

Internal Controls
Flow Navigation Centre Workstream
Hospital at Home Workstream
Front Door Workstream
DWD Collaborative
Dynamically using resources to reduce and mitigate risk of patient harm.
Whole System Frailty Workstream

Further Controls Required	Action Owner	Due Date	Latest Update
Enhance triumvirate support model within the Acute site to support implementation of the above.	Garry Fraser	30-Apr-2026	Progress continues to be made on this action and is now updated to 80%. There has been agreement to recruit to a fixed-term operational manager and a Project Support Officer. It is expected that this action will be completed by its due date.
Completion of the 12-week improvement plan and development of a robust workforce model.	Deborah Lynch	30-Jun-2026	Action has been updated to reflect the 12-week improvement plan. CfSD are helping the front door benchmark their workforce model and a meeting is in place to start progressing the 12-week improvement plan. Due date extended to end of June-26.
Access to electronic data to Flow Navigation Centre.	Deborah Lynch	31-Mar-2026	Action cancelled as it has merged with another Flow Navigation action.
Review the Flow Navigation Centre to review movement to a Senior Decision Maker Model.	Deborah Lynch	31-Mar-2027	National west group discussing flow nav and are looking at regional models. Review all aspects of FNC both at local and national level to deliver a robust and sustainable service moving forwards. Due date extended to March-27.

Strengthen access to community pathways and discharge to assess model.	Deborah Lynch	31-Mar-2027	Outcome measure will be continued improvement in reducing our delayed discharges and reducing length of stay. Reviewing step up/step down beds for frailty. Progress increased to 40%. Due date extended to March-2027.
Development of Hospital at Home Electronic Virtual Ward.	Deborah Lynch	30-Jun-2026	Progress continues to be made against this action and has increased to 60%. Due date has been extended to June-26.
Develop Adults with Incapacity (AWI) Process.	Jennifer Borthwick; Gail Woodcock	30-Jun-2026	FHSCP are looking at their local processes to support this process. Due date extended to June-26.
Implement learning from the National DWD Collaborative.	Deborah Lynch	31-Mar-2027	Started improvement ward in one ward. Focusing on A12 with a view to move to A31 afterwards. We will build on this as we go. Moving into year two of the collaborative. We are implementing learning as part of the improvement plans and will continue to engage in Y2 of the National DWD. Due date extended to March-27.
Increase Hospital at Home Capacity, including virtual capacity, in line with SG request.	Fiona Murray	31-Dec-2026	Progress is being made against this. This ties in together with Electronic Virtual Ward. 20% progress – people in post for OPAT and respiratory.

SRR 003 Information Governance		Current Score	Managed By	Assigned To
Risk Description	If NHS Forth Valley fails to implement and embed effective and consistent Information Governance arrangements, there is a risk we would experience systemic compliance issues and inability to use our information assets effectively, resulting in reputational damage and potential legal breaches leading to financial penalties.	12	Andrew Murray	Sarah Hughes-Jones
		Target Score	**Lead Impact Category**	**Appetite Level**
		8	Inspection/Audit	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		19-Mar-2026		Moderate (12-16)

Latest Update
Risk is subject to a focused review and will be updated to reflect the outcome of this position. Meanwhile progress continues to be made on the mitigating actions.

Internal Controls
Robust, and regularly reviewed, procedures which address information handling available to all staff involved in the activity.
Adherence to IG assurance processes & documentation (Information Assets, DPIA, ISA, Contracts, Risk Assessments, Privacy notices).
Use of approved devices, systems, and channels.
Active supplier management (as required).
Routine review and disposal processes. Ensuring regular deletion of redundant, obsolete, trivial material.
Annual information governance training & awareness.
Technical & Physical Security controls to manage access & audit.
Secure & backed up storage arrangements which avoid use of moveable media.
Effective and consistent use of filing systems, structured on Business Classification Scheme.
Identifying records for permanent preservation.
Identifying critical records within local business continuity plans
Information Governance Security Incident Management process
Routine processes to check & update information over time.

Further Controls Required	Action Owner	Due Date	Latest Update
SharePoint roll out (dependent on National O365 delivery)	Sarah Hughes-Jones	31-Jul-2026	SharePoint roll-out requires aligning with national delivery. Currently paused, awaiting direction. Due date extended of the action to reflect the above national changes but may change once national direction is confirmed.
Provide Information Risk Reports to all services who have logged critical assets, but which do not have a business continuity plan recorded.	Sarah Hughes-Jones	30-Apr-2026	The majority of Information Assets logged on the Information Asset Register have been reviewed and risk assessed. The exception is Acute which will be tackled separately due to the number and nature of assets registered and process required to identify gaps. A report on progress and next steps is planned for the Information Governance Group in April 26.

The IGU will analyse the data available from the dashboard and engage with services to identify targeted training solutions.	Sarah Hughes-Jones	31-Jul-2026	This action has not progressed to schedule due to reduced capacity within the Data Protection Team.
Ensure USB device management software enforces user-specific policies rather than allowing blanket access for specific USB models, preventing unauthorised or unintended use.	Sarah Hughes-Jones	31-Jul-2026	This action has not progressed as planned due to capacity challenges within the Cyber team.
Our reliance on suppliers is better understood with a degree of assurance especially around our critical suppliers' processes, policies and people.	Sarah Hughes-Jones; Scott Jaffray; Kurt McLay	31-Jul-2026	Work on improving supply chain security has progressed significantly. The Supply Chain Management Short Life Working Group (SLWG) has completed its review and produced final recommendations, including the transition of implementation activities to the Cyber Resilience Working Group, with quarterly reporting to IGG. The review included analysis of recent supplier cyber incidents (e.g., Nova Biomedical) and reinforced the need for strengthened third-party assurance processes. Next steps include: onboarding suppliers into Panorays once access is fully enabled, launching the Microsoft Supplier Assessment Form as the formal intake method for supplier assurance, and beginning alignment of the supplier list with NCSC supply chain mapping expectations.

SRR 004 Scheduled Care		Current Score	Managed By	Assigned To
Risk Description	If NHS FV does not consider and plan for current and future changes to population and associated demand/case-mix, there is a risk that the model for delivery of planned care will not meet demand or prioritise effectively, resulting in poorer patient outcomes, avoidable harm and failure to meet targets.	20	Garry Fraser	Marie Gardiner
		Target Score	**Lead Impact Category**	**Appetite Level**
		10	Patient Harm	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		06-Feb-2026		Moderate (12-16)

Latest Update
This risk has been reviewed in line with the new national planning structure, as per the request from the Clinical Governance Committee. The risk description has been reviewed in light of this and now reflects the introduction of the national sub-planning structure. At present, how the national planning structures will operate is still being developed. It is felt that when a clear direction has been set, then the further detail around risk score and mitigations will be updated.

Internal Controls
Scheduled Care Performance Management
Scheduled Care - Cancer Pathways
Annual Delivery Plan
NRAC Funding
Consultant Job Plans.
Non-medical staff delivering clinic and surgical based interventions releasing consultant time to do complex cases.

Further Controls Required	Action Owner	Due Date	Latest Update
Implementation theatre efficiencies programme to improve efficiency and to address impacts of patients repatriated from GJ, and loss of additionality allocation from GJ across multiple services.	Marie Gardiner	31-Mar-2027	

SRR 005 Financial Sustainability		Current Score	Managed By	Assigned To
Risk Description	If our recurring budget is not sufficient to meet the recurring cost base there is a risk there will be an increasing recurring gap in our finances, resulting in an inability to achieve and maintain financial sustainability, a detrimental impact on current/future service provision and an impact on our reputation.	25	Scott Urquhart	Jillian Thomson
		Target Score	**Lead Impact Category**	**Appetite Level**
		15	Financial	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		19-Mar-2026		Moderate (12-16)

Latest Update

This risk has been reviewed and there is no change to the risk at this point. Work continues to be made on the mitigation.

Internal Controls

Optimise the Value from Medicines Spend.

Maximise the Value from Workforce Spend

Financial Sustainability Action Plan

Communications Programme

Cost Awareness Programme

Systems & Controls in Place to Maximise Income Generation.

Further Controls Required	Action Owner	Due Date	Latest Update
Medium Term: Develop a plan which allows services to re-design within available resources (VBH&C).	Scott Urquhart	31-Oct-2026	The VBH&C Collaborative launched in January which will support this action. It will require services to work through a process around their finances. The date of this action has been extended to October-26 to allow for the collaborative to progress and to identify learning on the process. To further support this initiative, the finance team are recruiting to a dedicated VBH&C resource to support the delivery of this programme.
Finalise decisions around unfunded services.	Scott Urquhart	31-Jul-2026	This action is being monitored through the Financial Sustainability Programme Board. It is known where these services and work is progressing with services to ascertain next steps. Due date extended to July-26.
Development of a Financial Stewardship Toolkit.	Jillian Thomson	31-Jul-2026	A draft version of this has been developed and is being socialised across different teams. Progress has been marked at 50%. Once a final version has been completed this will be communicated to the organisation via different routes. Due date extended to July-26 to allow these final steps to occur.

SRR 009 Workforce Plans		Current Score	Managed By	Assigned To
Risk Description	If NHS Forth Valley does not implement effective, fully costed strategic workforce planning based on projected demand there is a risk that we will not have a sustainable workforce that is the right size, with the right skills and competencies, within an affordable budget, resulting in significant pressures on staff health and wellbeing, sub-optimal service delivery to the public and increasing pressure on our financial sustainability.	15	Kevin Reith	Linda McGovern
		Target Score	**Lead Impact Category**	**Appetite Level**
		10	Financial	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		26-Feb-2026		Moderate (12-16)

Latest Update

This risk has been reviewed by the People Director and there is no change to the risk score at this review. Some of the actions have been reviewed to reflect current progress made towards targets.

Internal Controls

Overarching Workforce Plan

Demographic Profiling

Directorate/Service Workforce Plans

Wellbeing Controls

Sustainable Workforce Initiatives

e-Rostering Solution

Attendance Management Action Plan

Nursing, Midwifery & Allied Health Professional (NMHAP) Workforce Tools

Safe Staffing Legislation

Regional Workforce Solutions

Further Controls Required	Action Owner	Due Date	Latest Update
Increasing employability through Anchor Institution Work.	Kevin Reith	31-Mar-2026	Agreement in principle for increasing employability as it was endorsed by WSLT. A plan is in progress for being developed to outline our commitment. 75% progress.
Action Plan which will include definitive and quantifiable actions to address identified staffing gaps.	Michael Brown	31-May-2026	All services asked to provide workforce plan by end of March and high-level data is being collected for the March-26 Staff Governance Meeting. Final Workforce plan to be presented at SGC in May-26. Progress increased to 90%.
Completion of the workforce actions in relation to the financial sustainability plan.	Kevin Reith	31-Mar-2027	Due date extended to March-27 to allow further work to be conducted on the workforce actions within the FSP. Progress increased to 50%.

Create directorate/service level workforce plans to inform the wider workforce plan.	Michael Brown	31-Mar-2026	Operational Workforce Planning Group workplan to March-26. This group has met twice now and has a clear plan on how to create Directorate Service Pans. The SWPB advised Service leads that they will be contacted around this to provide information and further inform future workforce projections for the 26/27 plan. Progress increased to 30%.
Undertake exercise to understand what capacity is needed to address and support staff regarding the implementation of attendance management controls and develop plan to address capacity needs.	Kevin Reith	31-Mar-2026	Fixed term posts approved to support focused attendance management action through a spend to save agreement. This is within Nursing and HR. Progress increased to 90%.

SRR 010 Estates & Supporting Infrastructure		Current Score	Managed By	Assigned To
Risk Description	If a whole system, multidisciplinary approach is not applied, there is a risk that we will not make best use of available capital and revenue funding, via prioritisation and allocation, to fully proceed with existing Estates and Infrastructure plans, make new development plans, or maintain and enhance the existing estate. This will result in an inability to maintain and develop a suitable environment for modern and sustainable services.	12	Morag Farquhar	Andrew McGown
		Target Score	**Lead Impact Category**	**Appetite Level**
		6	Service Delivery/Business Interruption	Averse (1-6)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		02-Mar-2026		Cautious (8-10)

Latest Update

This risk has been reviewed with the Director of Facilities and there is no change to the risk score at this review. Progress continues to be made on the mitigating actions however, we await Scottish Government direction on parts of the process. Our risk continues to be mitigated by the Formulary Capital Application and we continue to utilise the Business Continuity Process for further remedial works.

Internal Controls

NHS Board Capital Plan

Strategic Asset Management System

Rolling estate survey programme carried out within 5-year cycle

Planned Preventative Maintenance

Prioritisation of Revenue and Capital Budget

Horizon scanning

SCART - Statutory Compliance Audit and Risk Tool

Estates and Capital Planning Service Delivery

Facilities Management Tool.

Further Controls Required	Action Owner	Due Date	Latest Update
Develop a report to provide oversight on the backlog of maintenance which will be supplied as part of good governance.	Morag Farquhar	31-Dec-2026	Consideration given to how we will present the output from completion of SG proformas in the first quarter of 26/27.
Development of a property strategic plan to support the implementation of the Population Health & Care Strategy which will help inform the Board's capital plan. This should consider the resources available to deliver this.	Morag Farquhar	31-Dec-2026	Discussion held with Hub East Central currently confirming scope of healthcare planner service for tendering to supply chain.
Prioritise recruitment based on areas of risk.	Morag Farquhar	30-Jun-2026	First of the recruitment processes is in progress due to complete in March-26. Start date will depend on the notice period. This is for the Head of Capital Planning & Property.

Seek or ring-fence other funds to fully complete the rolling Estate Survey Programme.	Morag Farquhar	31-Dec-2026	Initial contact has been made within Finance to assess the feasibility of using capital funds to support estate survey programme & the comprehensive drawing database of our estate.
Engage with national process around primary care premises (national baseline) to inform first steps around the business case processes for primary care estate in FV.	Morag Farquhar	30-Jun-2026	FV are engaged in national meetings and are kept as well informed of SG direction. No confirmed date for Board discussion with SG around primary care premises. This will need to form part of the discussion for the Capital Asset Management Steering Group (replacing the Infrastructure Programme Board).

SRR 011 Digital & eHealth - Infrastructure & Strategy		Current Score	Managed By	Assigned To
Risk Description	If NHS FV does not develop and effectively implement a Digital and eHealth strategy which enables transformation and improvement as well as minimising technical vulnerabilities, there is a risk that other key organisational strategies cannot fully deliver the intended benefits, or the IT infrastructure could fail, impacting on long-term sustainability and efficient and effective service delivery.	20	Scott Jaffray	Rachel Marshall
		Target Score	**Lead Impact Category**	**Appetite Level**
		6	Service Delivery/Business Interruption	Averse (1-6)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		20-Mar-2026		Cautious (8-10)

Latest Update
Risk remains the same - Digital IT/Cyber continue to work through NIS Recommendations. Cyber Vault requires refresh - in Planning

Internal Controls
Annual Digital and eHealth Delivery Plan
Lifecycle System matrix
Cyber Security
Windows/Office Programme
FVRH ICT Infrastructure Upgrades
Disaster Recovery and Business Continuity Plans
Digital Directorate Workforce Plan.
Ensure alignment of new digital & eHealth proposals are linked to current strategies of the Board and national.
Accredited by the Service Desk Institute Standard.

Further Controls Required	Action Owner	Due Date	Latest Update
Increase the number of digital champions across the organisation to enhance digital/clinical partnership working.	Scott Jaffray	31-Mar-2026	Work continues to progress this action - will feed into directorate review. Due date extended to August-26.

SRR 015 Cyber Resilience		Current Score	Managed By	Assigned To
Risk Description	If NHS Forth Valley do not maintain the effectiveness of current cyber security controls and implement improvements to security controls where possible. There is a risk that the cyber security of the organisation may be compromised Resulting in a significant disruption to the services delivered by the organisation and an impact to the confidentiality, integrity, and availability of systems and data.	20	Andrew Murray	Sarah Hughes-Jones; Scott Jaffray
		Target Score	**Lead Impact Category**	**Appetite Level**
		16	Service Delivery	Averse (1-6)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		19-Mar-2026		Cautious (8-10)

Latest Update
This risk has been reviewed and there is no change to the risk score at this time. Progress has been marked against the actions mitigating the risk.

Internal Controls
NIS Audit Recommendations
Enhanced ICT Infrastructure Business Continuity / Disaster Recovery
Digital Delivery Plan 22/23
Cyber Security Awareness Strategy.
Cyber Resilience Awareness Training
Cyber Resilience Framework
Digital and eHealth Strategy to outline funding arrangements for cyber.
Local Policies & Procedures
Change Management processes to include cyber.
Cyber Training & Simulations.
Asset Management
System Management
Threat Intelligence Processes
Vulnerability & Patch Management
Utilisation of Security Tools
Communication and awareness
Cybersecurity & Operational Staffing and Capability Development
Supplier Management
Access Control
Media Management
Operational & Network Security Management
Business Continuity & Disaster Recovery
Privileged Access Management (PAM) & Administration account management
Cyber Change Management Processes

Further Controls Required	Action Owner	Due Date	Latest Update
Continuous improvements and monitoring of our awareness material and training for all staff.	Sarah Hughes-Jones; Scott Jaffray	31-July-2026	Following all-staff phishing test completed in December, the full results have now been analysed and are informing targeted departmental training interventions focused on areas with higher click and credential-submission rates. Behaviour-specific follow-up training is being prepared for individuals and teams identified as requiring additional support. Work is also underway to scope the procurement of a dedicated cyber awareness training platform to enhance staff engagement, improve behavioural measurement, and support progression toward Stage 3 of the SANS Security Awareness Maturity Model.
Our reliance on suppliers is better understood with a degree of assurance especially around our critical suppliers' processes, policies and people.	Sarah Hughes-Jones; Scott Jaffray	31-July-2026	Work on improving supply chain security has progressed significantly. The Supply Chain Management Short Life Working Group (SLWG) has completed its review and produced final recommendations, including the transition of implementation activities to the Cyber Resilience Working Group, with quarterly reporting to IGG. The review included analysis of recent supplier cyber incidents (e.g., Nova Biomedical) and reinforced the need for strengthened third-party assurance processes. Next steps include: onboarding suppliers into Panorays once access is fully enabled, launching the Microsoft Supplier Assessment Form as the formal intake method for supplier assurance, and beginning alignment of the supplier list with NCSC supply chain mapping expectations.
Business Continuity Plans – Embedding and testing - BCPs should be widely known, understood, and regularly tested for effectiveness.	Sarah Hughes-Jones; Scott Jaffray	31-July-2026	Work to strengthen the testing and embedding of Business Continuity Plans has continued. Planning is now underway to begin cyber-focused continuity exercising in Q1 2026, including the initial rollout of *Exercise in a Box* scenarios to assess organisational readiness. A meeting has been scheduled with our incident response specialists (NCC group) to explore how they can support us in practising a realistic, live incident scenario. These activities will help ensure that BCPs are not only documented but actively tested and embedded across services, supporting improved organisational resilience going forward.
Develop a Gatekeeping process for third party access.	Scott Jaffray	31-July-2026	Work on formalising the gatekeeping process for third-party access continues to be led by Digital and Compliance, with Cyber/IG providing input where required. The draft documentation has been completed and is currently awaiting final agreement and adoption. The process continues to be applied to new suppliers, with ongoing work to embed it consistently for existing suppliers. This action is now being aligned to the upcoming NIS submission deadline (26 January 2026), where the gatekeeping requirements form part of the assurance evidence.
Conduct a review of the current cyber resources to support effective change management. This will be included by the Digital Directorate Review. Further review to also be scheduled within IGU.	Sarah Hughes-Jones; Scott Jaffray	31-Mar-2026	Job Evaluation process has re-evaluated CISM to a Band7, enabling immediate recruitment process can commence. Review still required around the overall risk as retention issues not mitigated. Due date reviewed and extended to December-25 to allow for recruitment
Completion of actions related to Cyber Resilience Focused Review.	Kurt McLay	30-Sep-2026	To separate out the operational information from the strategic risk, the focused review actions, that are being progressed have been merged under this action. This will allow the Board to keep tracking progress on them, without giving too much operational information. As it stands, there is 53% progress made on completing these actions.

SRR 017 Environmental Sustainability & Climate Change		Current Score	Managed By	Assigned To
Risk Description	If NHS Forth Valley does not maximise our available resources to implement our Climate Emergency & Sustainability Strategy, there is a risk that we will be unable to comply with DL38 and not meet requirements of the Scottish Government Climate Emergency & Sustainability Strategy resulting in an inability to operate in an environmentally sustainable manor, an inability to meet objectives, and damaging stakeholder/public confidence.	20	Morag Farquhar	Derek Jarvie
		Target Score	**Lead Impact Category**	**Appetite Level**
		15	Environmental Sustainability/Climate Change	Moderate (12-16)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		02-Mar-2026		Open (20-25)

Latest Update

This risk has been reviewed with the Director of Facilities and the Head of Environmental Sustainability. There is no change to the risk position at this review. Progress continues to be made on our mitigating actions.

Internal Controls

Climate Emergency Response and Sustainability Team

Climate Change & Sustainability Team

Board Papers Contain Section on Environmental Sustainability Considerations

Climate Emergency & Sustainability Strategy and Action Plan

Continual review and identification of funding sources.

Further Controls Required	Action Owner	Due Date	Latest Update
Successful Implementation of the Environmental Management System.	Derek Jarvie	31-Mar-2026	No movement on this action as resources within the team is stretched. Due date is extended to March-27.
Recruit the Waste and Compliance Support Officer role.	Derek Jarvie	31-Mar-2026	This post is currently undergoing the recruitment review process, therefore progress has increased to 40%. To allow for this process to continue and to allow time to recruit to a new post, the due date has been extended to Septermber-26.
Development of an energy strategy.	Derek Jarvie	30-Jun-2026	The development of this strategy has been paused to allow for the recruitment of the new energy manager. Due date extended to Sep-26.

SRR 018 Primary Care Sustainability		Current Score	Managed By	Assigned To
Risk Description	If we do not have adequate resources to support and implement a Primary Care Framework, there is a risk that we don't have effective measures to ensure delivery of primary care to patients across Forth Valley, resulting in an impact on patient care through failure to meet our statutory responsibilities and deliver on the aims of the Population Health & Care Strategy.	15	Gail Woodcock	Scott Williams
		Target Score	**Lead Impact Category**	**Appetite Level**
		10	Patient Harm	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		19-Mar-2026		Zero

Latest Update

This risk has been reviewed by the Primary Care Lead and there is no change to the risk score at this time. Scottish Government have committed additional funding for General Practice which is expecting to reduce the risk exposure. At the point of review, it is unclear what the direct impact will be on FV Primary Care Services. Once this has been received, the risk score will be revisited.

Internal Controls

GP Sustainability Loans in Place (Finance, Recruitment & Retention).

Primary Care Improvement Plan (Capacity & Demand).

Expansion of community pharmacy services (Further development of Pharmacy First Service) (Capacity & Demand).

Regular engagement with SG and BMA in place regarding national MOU funding (Capacity & Demand).

Recognised process to consider all options when a practice is handed back to NHS FV (Capacity & Demand).

Targeted recruitment to build GP and MDT capacity and capability (Recruitment & Retention).

Capital Investment Programme (Recruitment & Retention, Premises).

Further Controls Required	Action Owner	Due Date	Latest Update
Development of Governance routes and escalation procedures following the delegation of PC to FHSCP.	Tom Cowan; Scott Williams	31-May-2026	The Primary Care Programme Board is established (meetings in Dec 25 and Feb 26), draft Terms of Reference in development for the group. Joint IJB workshop will explore Primary Care Governance and principles for formally hosted services to occur in April with subsequently reported to all appropriate bodies. Due date extended to May-26.
Communicate with GPs around the NHS recruitment process to understand sign off points.	Louise McCallum	30-Apr-2026	Primary Care Lead liaising with Medical Workforce to ascertain the process conducting after point of vacancy being approved through to member of staff starting. Action updated to reflect this and due date extended. Once received it will be communicated via PCIP oversight group. Due date extended to May-26.
Engage with national process around primary care premises (national baseline) to inform first steps around the business case processes for primary care estate in FV.	Morag Farquhar	30-Jun-2026	FV are engaged in national meetings and are kept as well informed of SG direction. No confirmed date for Board discussion with SG around primary care premises. This will need to form part of the discussion for the Capital Asset Management Steering Group (replacing the Infrastructure Programme Board).

Development of a Primary Care Strategy to consider current and future analysis of services delivered through other community patient pathways (e.g., Community Pharmacy) with an aim to mitigate and reduce the strain on core services.	Louise McCallum	31-March-2027	This is a complex process as there are various moving components. It will be included in the development of the Primary Care Strategy. A collaborative approach to this will be taken across these pathways. Due to the complexity, the due date of the action has been extended to 31-March-2027.
Long term strategy and recurring resource needed to deliver on recommendations such as Golden Hello recruitment grants, coaching and mentoring, infrastructure.	Louise McCallum	27-Feb-2026	The Additional investment from SG will come with guidance to ascertain whether we can use the money to support some of these workforce initiatives. Any guidance and local decisions will be tracked through the GP Sustainability Group. Due date extended to 30-June-26 to allow for clarity on guidance.
Review management of vacancies within PCIP.	Nickola Jones	30-Apr-2026	Action title updated to reflect management of vacancies within PCIP. This action is being tracked by the PCIP Oversight Group. Due date extended to December-26.

SRR 019 Culture & Leadership		Current Score	Managed By	Assigned To
Risk Description	If NHS FV do not foster a cohesive culture with strong leadership, there is a risk that our people will not feel valued in their roles and understand how they feed into organisational success, resulting in a negative impact on staff morale, and an inability for FV to be resilient, agile and achieve long-term success.	15	Kevin Reith	Margaret Kerr
		Target Score	**Lead Impact Category**	**Appetite Level**
		10	Inspection/Audit	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		26-Feb-2026		Moderate (12-16)

Latest Update

This risk has been reviewed by the Director of People and there is no change to the risk score at this meeting. Good progress has been made on the mitigating actions and updates have been marked against those that are in progress. The Culture Change & Compassionate Leadership Programme is moving towards closure, and it is felt that once we have established robust business as usual governance, then the risk could reduce in risk score. This will be taken into consideration in the next focused review of SRR019.

Internal Controls

Whistleblowing procedures including “Speak Up” service.

Communication - Resources supporting development of culture are available on the intranet.

Personal Development Reviews

Promotion of yearly iMatter surveys across the organisation.

Celebrating Success

Culture Change and Compassionate Leadership Programme

Organisational Development Programme

Leadership Programme.

Peer Support and Wellbeing Teams in place to support staff.

Induction Processes

Step into my Shoes Initiative.

Further Controls Required	Action Owner	Due Date	Latest Update
Strengthen educational governance to ensure educational activity is supporting delivery of our strategic aims. The introduction of the Strategic Workforce Programme Board will support this.	Jenny McCusker	30-Jun-2026	The remit of the Practice Development Governance Committee is to be extended to all non-medical training and a sub-group for generic learning and education created. Progress increased to 80% to reflect this, and the due date has been extended to June to allow for this change to work through.
Great communications team to review ways in which we can engage effectively beyond staff net alone.	Sarah Hughes-Jones	30-Jun-2026	One of the outputs of the Values workstream from Culture Change Programme has been the agreement to use our Interactive Employee journey as focus for our staff engagement work. In addition a plan is being developed for a practical toolkit guide which will sit within a new communications framework refresh. This work will be completed as part of mainstreaming activity by 30 June 2026.

Engage with Head of OD regarding the communication aspect of leadership development.	Jenny McCusker	30-Apr-2026	The new leadership event is due to be launched on the 2nd of April and with it, will create a new leadership community, supporting line managers around all aspects of leadership. Due date extended to April-26 to allow for this event to be launched formally.
Get connected team looking at improving communication between FV and partnership organisations.	Sarah Hughes-Jones	31-May-2026	The next Step in my Shoes will go live in May 2026. Due date updated to reflect this.
Develop cultural indicators which will be used to inform assessment of progress around improving culture.	Jo Tolland	31-May-2026	Discussed at the last Staff Governance Committee and it was agreed to bring this process back to the Committee at a later date for further discussion.
Develop the process which identifies leadership talent, directs to the appropriate development activity and evaluates effectiveness.	Jenny McCusker	30-Apr-2026	The leadership and management framework is aligned to 5 levels of leadership and supports career progression.
Review the leadership development programme and make recommendations to ensure it meets our leadership needs.	Jenny McCusker	30-Jun-2026	Main review completed with initial framework agreed with pilots of the initial priority programmes (Core Management Skills pilot is live & the design stage of Transformational Change Leadership is underway. Progress remains at 75% and the due date extended to June-26, to allow for this work to finalise.
Develop a measurement framework which is built into the leadership development plan to support evaluation of effectiveness in improving organisational performance.	Jenny McCusker	30-Jun-2026	Work on track with performance dashboard development progressing to align to the new framework.
Strengthen educational governance to ensure educational activity is supporting delivery of our strategic aims. The introduction of the Strategic Workforce Programme Board will support this.	Jenny McCusker	30-Jun-2026	The remit of the Practice Development Governance Committee is to be extended to all non medical training and a sub-group for generic learning and education created. Progress increased to 80% to reflect this, and the due date has been extended to June to allow for this change to work through.

SRR 020 Health Inequalities		Current Score	Managed By	Assigned To
Risk Description	If NHS FV does not work with partners to influence the social determinants of health and the NHS does not create a healthcare system which can be accessed by all the people of Forth Valley, there is a risk that health outcomes do not improve, and health inequalities do not reduce or may even widen. This could result in reduced healthy life expectancy for the population, or for individual population groups, and a significant financial cost through increased need and demands on services.	20	Jennifer Champion	Andrew Murray
		Target Score	**Lead Impact Category**	**Appetite Level**
		10	Health Inequalities	Cautious (8-10)
		Last Review Date	**Risk Trend**	**Tolerance Level**
		19-Mar-2026		Moderate (12-16)

Latest Update

This risk has been reviewed and there is no change to the risk position at this review. Work is progressing on the mitigating actions and work is underway to develop the Focused Review on this risk.

Internal Controls

NHS Forth Valley is an Anchor Institution, working with other partner organisations in their role as Anchor Institutions, to improve the social determinants of health.

Director of PH work collaboratively across the local population health system with CPPs to embed tackling inequalities as a principal theme.

NHS Forth Valley senior planners and managers contribute to multiple Community Planning Partnership theme groups to plan for improved health outcomes and reduced inequalities.

Anchor NHS service design planning commenced with strategic leads and service managers to improve reach and benefit of services and programmes for diverse and disadvantaged communities.

Directors of Public Health are working with Heads of Population Health at the Scottish Government with a view to intelligence performance management around Health Inequalities activity.

Commenced work with HR re revamped EQIA with a poverty/health inequalities focus.

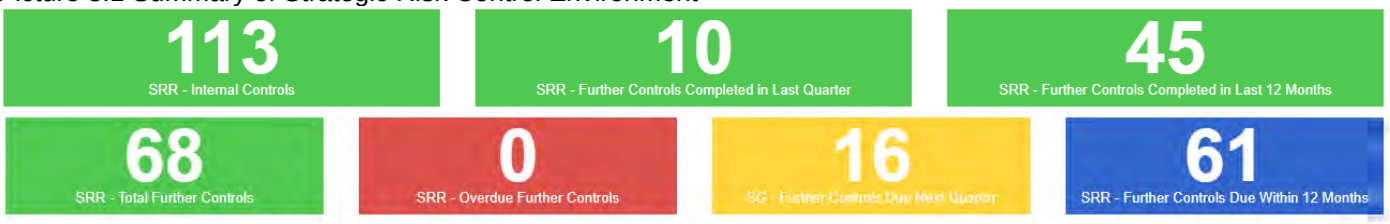
Healthcare PH Consultant understanding health inequalities and barriers to paediatric outpatients.

Further Controls Required	Action Owner	Due Date	Latest Update
Development of a comprehensive healthcare inequalities delivery plan which supports investment in measures and embeds HI into all workstreams.	Jennifer Champion	30-Jun-2026	Work is progressing around the development of this plan to build on good practice occurring within the organisation. Due date extended to June-26.
Health Inequalities delivery plan should be aligned with partnership plans - Discuss at ELT and Board Seminar.	Jennifer Champion	31-Mar-2026	Work is progressing around the alignment of plans build on good practice occurring within the organisation. Due date extended to June-26.
Work with NES around staff accessing training to understand responsibilities around health inequalities - this is a key enabler to embedding prevention activity.	Jennifer Champion	31-Mar-2026	Work is progressing on this action, due date extended to May-26.

Develop a systematic way to assess and monitor health inequalities.	Jennifer Champion	27-Feb-2026	Work is progressing to develop alignment on performance indicators for health inequalities. Due date extended to June-26.
Review NHS Forth Valley contribution to community planning partnerships.	Jennifer Champion	31-Mar-2026	Work is progressing to align delivery plans across the community planning partnerships. Due date extended to October-26.

3.Risk Controls Progress Update

Picture 3.1 Summary of Strategic Risk Control Environment



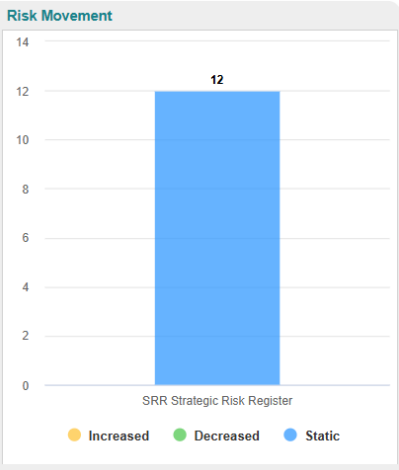
In this reporting period, there are 113 current controls mitigating these risks. Supporting our control environment, there were 10 actions completed in this reporting period which further mitigate the strategic risk profile (Table 3.1 highlights these actions). At the end of this reporting period there are no overdue actions reported, with a further 21 actions due to be completed by Quarter 1 (26/27).

Table 3.1 Strategic Risk Completed Actions

Action Code	Action Title	Due Date	Action Owner
SRR015.21	Conduct Board-wide phishing simulation test.	31-Jan-2026	Sarah Hughes-Jones; Kurt McLay
SRR003.16	Finalise the onboarding of TrakCare with FairWarning and update the FairWarning guidance document.	27-Feb-2026	Sarah Hughes-Jones
SRR002 FRA	Implementation of a Frailty 7-day service.	31-Mar-2026	Deborah Lynch
SRR005.25	Implementation of the Finance Recovery Plan.	31-Mar-2026	Scott Urquhart
SRR009.14	Develop a joined-up approach to the whole-system workforce plan.	31-Mar-2026	Michael Brown
SRR009.15	Establish confirmed baselines of our workforce across NHS Forth Valley.	31-Mar-2026	Michael Brown
SRR019.13	Create an OD Plan aligned to the organisational needs, supporting the people strategy.	31-Mar-2026	Jenny McCusker
SRR019.15	Reviewing mandatory/statutory training and align with the national developments.	31-Mar-2026	Jenny McCusker
SRR019.20	Directorates to come up with action plans to increase compliance with PDPs.	31-Mar-2026	Jenny McCusker
SRR011.10	Establish a benefits realisation process to document and report on all identified benefits within digital projects.	31-Mar-2026	Scott Jaffray

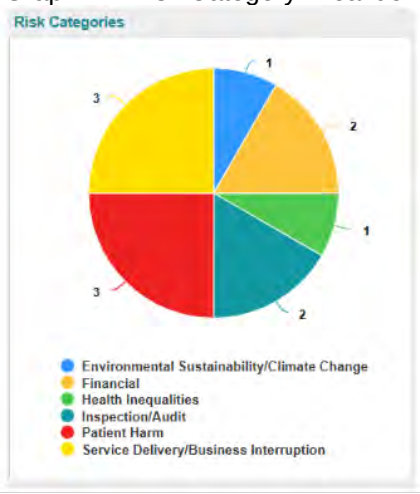
4.Risk Trend Analysis

Graph 4.1 Risk Register Activity



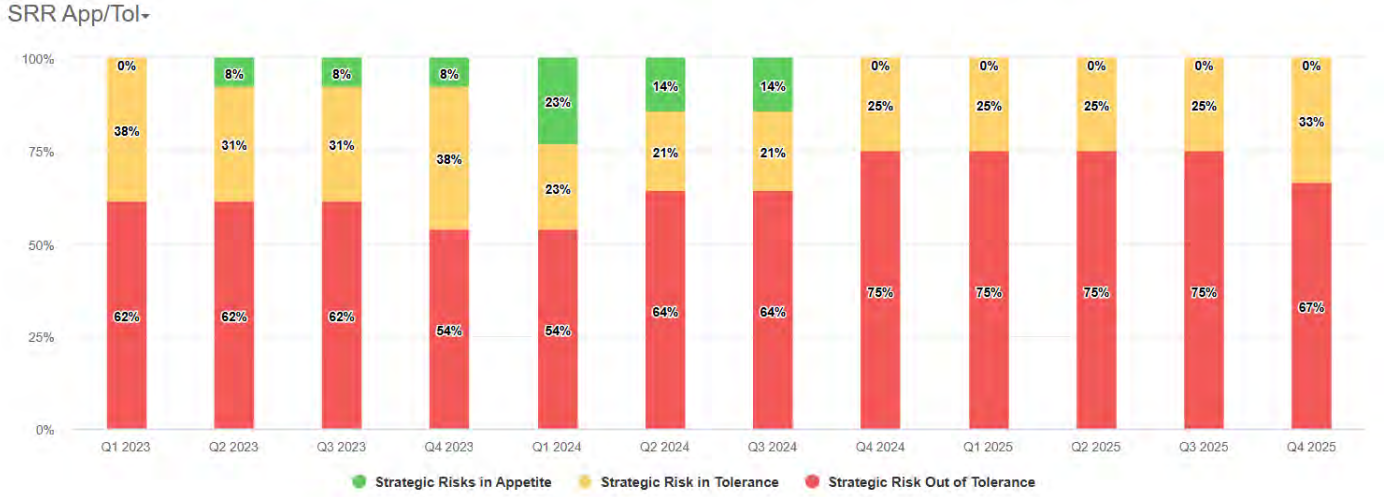
The chart to the left shows that across the Strategic Risk Register all risks remained static in this review period.

Graph 4.2 Risk Category Breakdown



When risks are assessed, a lead impact category is selected, which sets the appetite/tolerance level for the risk. The chart to the left shows that Service Interruption and patient harm are the highest categories, followed by Finance & Inspection/Audit. The remaining risks are split between Environmental Sustainability and Climate Change and Health Inequalities.

Graph 4.3 Strategic Appetite and Tolerance



A graph depicting the risk appetite profile of the strategic risks across the previous financial year:

- Quarter 1 (25/26) remained static, despite the increase in risk score for SRR011 as it was already listed as out with the Boards appetite and tolerance.
- Quarter 2 (25/26) remained static, despite the decrease in score for SRR010, as it remains outside the Boards appetite and tolerance.
- Quarter 3 (25/26) remained static.
- Quarter 4 (25/26) is on track to reduce the number of risks out with the Boards appetite and Tolerance with SRR009 reducing in risk score. 33% of the Boards Strategic Risks are within Tolerance levels and 67% of the Boards Strategic Risks are out with appetite and tolerance.

Note that the colours in the chart represent status (In appetite, In Tolerance, Out of Tolerance) rather than score.

5. Strategic Risk Assurance Focused Reviews

There were no focused reviews conducted in this reporting period. A focused review on SRR003: Information Governance is in process of being completed and will be sighted at Strategic Planning, Performance & Resources Committee on the 31st of March. Details of this will be included in the next reporting period.

SRR003: Information Governance

Commentary
During this focused review process, there was a no change to the overall description of the risk, and the overall risk score remains the same. A review of the current and further controls was conducted, highlighting a variety of ratings for these controls. An improvement was noted in the control environment and a section on key steps required to further mitigate the risk into the Boards appetite.

BETTER VALUE								
5. Demonstrate best value using our resources								
SRR003	**Information Governance** If NHS Forth Valley fails to implement and embed effective and consistent Information Governance arrangements, there is a risk we would experience systemic compliance issues and inability to use our information assets effectively, resulting in reputational damage and potential legal breaches leading to financial penalties.	12	Robust proceudres in place.		X	X	X	Reasonable
			Adherence to IG assurance processes and documentation.		X	X	X	
			Use of approved devices, systems, and channels.		X	X	X	
			Active supplier management.			X	X	
			Routine review and disposal processes.		X		X	
			Information governance training & awareness.		X		X	
			Technical & Physical security controls to manage access & audits.		X	X	X	
			Secure & backed up storage arrangements.		X	X	X	
			Effective and consistent use of filing systems.		X	X	X	
			Identifying records form permanent presevation.		X	X	X	
			Idntifying critical records wih local business continuity plans.		X	X	X	
			Information Governance Security Incident Management Process.		X	X	X	
			Routine processes to check & update information over time.		X	X	X	

NHS Forth Valley

Forth Valley NHS Board

9. Risk Management Framework
Purpose: This report is for Decision

Executive Sponsor: Kerry Mackenzie, Acting Director of Strategic Planning & Performance
Author: Miss Vicky Webb, Head of Risk Management

Executive Summary

This report presents the revised Risk Management Framework.

Action Required

The Forth Valley NHS Board is asked to:

(1) approve the Risk Management Framework.
(2) approve the risk appetite levels for the Board as noted in the Risk Management Framework.
(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

This matter has previously been considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Senior Leadership Team to oversee the new approach to Risk Appetite.
- Audit & Risk Committee, 27th of March, to review and endorse the new risk management framework.
- Strategic Planning, Performance & Resources Committee, 31st of March to review and endorse the new risk management framework.
- The Risk Management Short Life Working Group, comprising of key executive and non-executives, were involved throughout the process of developing the risk appetite approach.

Risk Assessment and Mitigation

The report details the new risk management framework.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial and Infrastructure Implications

No financial implications of this paper.

Workforce Implications

No workforce implications of this paper.

Quality / Patient Care Implications

No quality/ patient care implications of this paper.

Population Health & Care Strategy

Effective risk management will support delivery of the Population Health & Care Strategy.

Climate Change / Sustainability Implications
No climate change implications.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

- If yes, please provide details.

Appendices
Appendix 1 – Risk Management Framework

Forth Valley NHS Board

Risk Management Framework

Current Issue date	19/09/2024	Date of First Issue	26/07/2022
Review Date	28/04/2026	Retention Period	Permanent
Version	3.0	EQIA	No
Owner (Author) & Role	Vicky Webb, Head of Risk Management		
Responsible Manager and Role	Kerry Mackenzie, Acting Director of Strategic Planning & Performance		
Approving Committee or Group	FV NHS Board	Approved	Yes

Management of Document Control Sheet

Type of Document	Framework
Level / Audience	Organisational
Publication	Internally and Externally
Purpose of document	To provide direction on how NHS FV will undertake risk management practices across the organisation, highlighting key roles & responsibilities and principles to adhere to.

Consultation and Change Record

Contributing Authors (Name & Role)		N/A	
Consultation Process		N/A	
Date	Author	Change	Version
26/07/2022	Sara MacKenzie	• Document developed.	1
19/09/2023	Sara MacKenzie	• Document reviewed.	2
19/09/2024	Sara MacKenzie	• Accessibility checked, content updated to reflect introduction of risk appetite, review timescales amended and addition of section 5 – Training, Learning and Development.	2.1
28/04/2026	Vicky Webb	• Updated to become a framework document. Content checked and updated to reflect best practice; risk appetite levels reviewed and updated. Procedural information removed and placed in own document.	3

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Statement of Intent

Effective Risk Management is a fundamental cornerstone of good Corporate Governance and Internal Control and is an essential component in delivery of the Health Board's strategic and corporate objectives. This Risk Management Framework has been written for, and with, staff and is intended to:

- Influence culture by helping staff better understand how to evaluate and take actions on all their risks to increase the probability of success whilst reducing the likelihood of failure.
- Ensure high conformity with applicable rules, regulatory regulations and mandatory obligations.
- Provide assurance to the Health Board, Integration Joint Boards and its Audit and Assurance Committees that risk management and internal control activities are proportionate, aligned, comprehensive, embedded and dynamic.
- Support decision making using a risk-based approach.
- Adopt 'rules of engagement' whilst working in partnership with external stakeholders that are clear and unambiguous to support a culture of engagement and collaboration.

A good understanding and awareness of risks, based on the identification, assessment and mitigation processes as outlined in this Framework, will enable the Health Board to successfully deliver the vision as set out in our Population Health & Care Strategy 2025-2035'.

I want NHS Forth Valley to be a high performing Health Board. High performing organisations have good governance and management arrangements in place. I believe effective risk management is a key component of these arrangements. This Framework aims to support a risk management culture that encourages us to be risk aware but not risk averse.

I want us to adopt good risk management behaviours and practice, and this will require all of us to be familiar with our systems, policies and processes and to be able to identify, assess and respond to risks within our operating environment. Training and support will be available to staff to underpin this Framework.

In summary, risk is unavoidable. It is an important part of life that allows us all to move forward and develop. Successful risk management is about ensuring that we have the correct level of control in place to provide sufficient protection from harm, without stifling our development, and encouraging staff to take risk where supported to do so. This Framework sets out our approach to risk management and outlines the key objectives and responsibilities for the management of risk throughout our organisation.

I believe we should not shy away from risk but instead seek to proactively manage it. This will allow us not only to meet the needs of today but also be prepared to meet the future challenges of tomorrow.

Ross McGuffie
Chief Executive

1. Introduction

The Risk Management Framework sets out the principles and approaches to risk management which are to be followed throughout NHS Forth Valley. Its aim is to achieve a consistent and effective application of risk management, enabling it to be embedded into all core processes, forming part of the day-to-day management activity of the organisation. Risk management, when deployed effectively, should add value by supporting day-to-day activities as opposed to being seen as a separate, self-contained process. The Risk Management Framework and supporting documentation supports this approach.

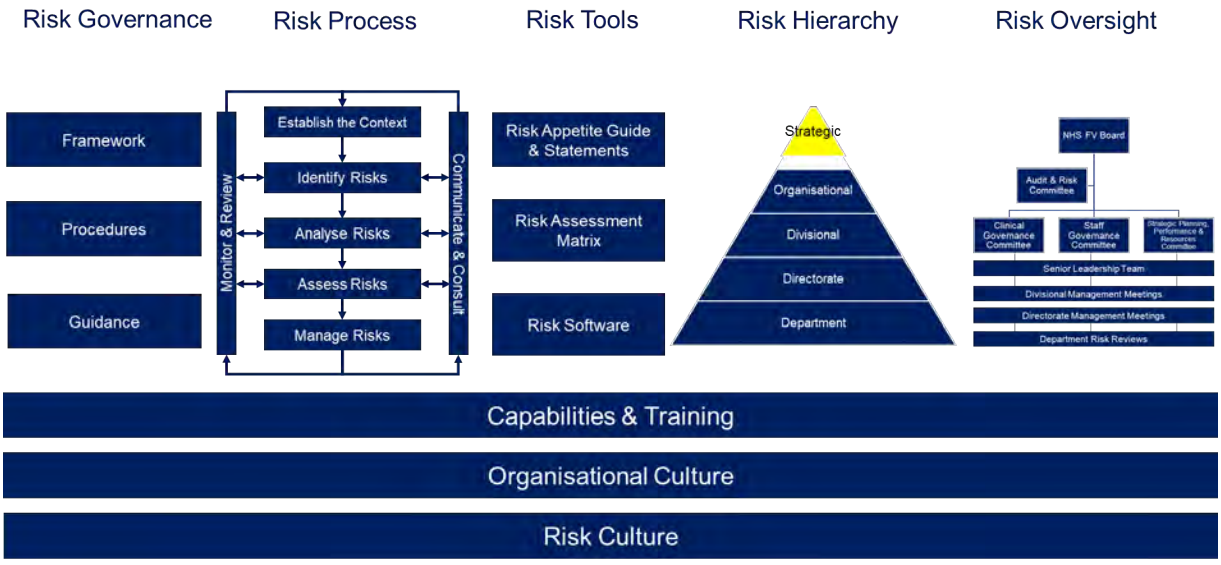
This Framework identifies the principles to risk management, the governance arrangements for risk and the additional tools utilised for implementing risk management. Supporting procedural and guidance documents are also available to aid the implementation of the framework. Specifically, these are:

- Risk Management Procedures
- Risk Appetite Guide & Supporting Statements
- Risk Assessment Matrix
- Control Assurance Guidance
- Pentana Risk Management Guides

The below diagram, diagram 1.1, aims to summarise the overall risk management approach but note that this is an indication only, and the practical application of the risk framework is more complex in nature.

This framework comprises of best practice from the ISO 31000 Standards, IRM Guidance, the Orange Book and relevant NHS Guidance.

Diagram 1.1 NHS FV's Risk Management Framework



2. Scope of Framework

This framework, and supporting guidance, applies to all staff, clinical and non-clinical, including contractors. All are to be aware of the contents listed within this document.

3. Risk Management Principles

For effective risk management to be discharged throughout the organisation, it is important that key foundational principles are established and effectively communicated throughout the organisation. The following principles, identified from the ISO3100 Standard, have been identified to support the application of this framework:

- **Integrated**
  - Risk management is an integral part of all organisational activities.
- **Structured & Comprehensive**
  - A structured and comprehensive approach to risk management contributes to consistent and comparable results.
- **Customised**
  - The risk management framework and process are customised and proportionate to the organisations external and internal context related to its objectives.
- **Inclusive**
  - Appropriate and timely involvement of stakeholders enable their knowledge, views and perceptions to be considered. Resulting in improved awareness and informed risk management.
- **Dynamic**
  - Risks can emerge, change or disappear as an organisational external and internal context changes. Risk management will anticipate, detect, acknowledges and responds to those changes and events in an appropriate and timely manner.
- **Best Available Information**
  - The inputs into risk management are based on historical and current information, as well as, on future expectations.
- **Human & Cultural Factors**
  - Human behaviour and culture significantly influence all aspects of risk management at each level and stage.
- **Continual Improvement**
  - Risk management is continually improved through learning and experience.

4. Definitions

4.1 What is Risk Management?

Risk Management is a systematic way of dealing with that uncertainty which involves the identification, analysis, control and monitoring of risk. Risk Management activities are designed to achieve the best possible outcomes and reduce the uncertainty. An effective system of risk management will draw together all categories of risks and enable a holistic view of the organisation's risk profile. This can also be referred to as Enterprise Risk Management.

4.2 What is a Risk?

A risk can be defined as 'the effect of uncertainty on objectives' (*ISO31000)*. It is any uncertain event impacting upon the achievement of an organisation's objectives. The term risk can be broken down into two types of risk, opportunities and threats. Opportunities are uncertainties

which may provide a positive impact upon the ability to achieve objectives, whereas threats are uncertainties which may provide a negative impact upon the ability to achieve objectives. NHS Forth Valley's Risk Management Framework aims to incorporate both types of risk when discharging its responsibilities.

4.3 Categories of Risk

When considering risk within a healthcare setting, recognition should be given to the numerous categories of risk that are managed throughout the organisation. The following table aims to give an overview of the principal categories of risk that the organisation is exposed to, providing clear definitions of each. Any changes to these will be agreed by the Senior Leadership Team and approved through the Board.

Table 4.3.1 Categories of Risk

Categories of Risk	Definition
Strategic	Risks which impact upon the delivery of the Boards strategic objectives.
Operational	Risks arising from inadequate, poorly designed or ineffective/ inefficient internal processes resulting in fraud, error, impaired customer service (quality and/or quantity of service), non-compliance and/or poor value for money.
Financial	Risks arising from not managing finances in accordance with requirements and financial constraints resulting in poor returns from investments, failure to manage assets/liabilities or to obtain value for money from the resources deployed, and/or non-compliant financial reporting.
Workforce	Risks arising from ineffective leadership and engagement, suboptimal culture, inappropriate behaviours, the unavailability of sufficient capacity and capability, industrial action and/or non-compliance with relevant employment legislation/HR policies resulting in negative impact on performance
Clinical	A risk impacting on the treatment or provision of care to an individual/s. Occurring from clinical investigation, clinical treatment or patient care provision within a pathway.
Programme/Project	Risks which impact on the ability to deliver a project/programme to the scope, time & budget set.
Information	Risks arising from a failure to produce robust, suitable and appropriate data/ information and to exploit data/information to its full potential.
Security	Risks arising from a failure to prevent unauthorised and/or inappropriate access to the estate and information, including cyber security and non-compliance with General Data Protection Regulation requirements.
Health & Safety	Risks arising from a failure to ensure, as far as is reasonably practicable, the health, safety and welfare of staff and others that may be affected by our work activities (those risks which impact on people out with the delivery of care).
Technology/Digital Infrastructure Risk	Risks arising from technology not delivering the expected services due to inadequate or deficient system/ process development and performance or inadequate resilience.

The above list is not exhaustive but intends to give an overview of the principal categories of risk managed within NHS Forth Valley. The intention behind adopting an Enterprise Risk

Management Framework is to provide an integrated overview of all risk exposure to NHS Forth Valley.

If any of the above categories of risk materialise, they could impact upon any of the following areas (as set out in the Risk Assessment Matrix – developed as part of the HIS Adverse Event Framework). These are known as impact categories and are where risk management is aligned to. The impact categories are:

- Injury/Illness
- Healthcare Experience
- Transformation/Innovation
- Service Delivery/Business Interruption
- Workforce
- Financial
- Compliance
- Public Confidence
- Health Inequalities

Further details on the impact categories can be found in the Risk Management Procedures.

4.4 Predictive, Proactive & Reactive Risk Management

There are distinct stages of risk management process which all mitigate risk in different ways. These stages can be referred to as predictive, proactive and reactive risk management processes. It is useful to understand this process to understand interdependencies and how learning will be identified across all these domains. These are described below.

Predictive Risk Management

- Predictive risk management uses data analytics and other vehicles to predict the occurrence of an event. Examples of activities covered under this:
    - Planning (Strategic, Clinical, Project, Emergency etc.)
    - Data Modelling
    - Horizon Scanning

Proactive Risk Management

- Proactive risk management aims to prevent the occurrence of an event. This is where traditional risk management practices are considered. Examples of activities covered under this are:
    - Health & Safety Control Book Management
    - Corporate Risk Management
    - Data Protection Assessments

Reactive Risk Management

- Reactive risk management is deployed when an event has occurred within the organisation with the aim to reduce the impact experienced as much as realistically possible. Examples of activities covered under this are:
    - Business Continuity Plans
    - Adverse Event Management
    - Claims Management
    - Crisis Management

4.5 Control Definitions

When identifying and managing risk, a critical component of the management of risk is the identification of controls. Controls are the measures put in place to mitigate the risk. There are different types of controls which could be utilised. Table 4.5.1 details these definitions. Further guidance on how to practically utilise controls can be found in the Risk Management Procedures.

Table 4.5.1 Control Definitions

Control Definitions		
Type	**Description**	**Examples**
Preventative	Activity to control the underlying risk cause and prevent it happening in the first place	• Removal / substitution of a hazard • Employee vetting / checks • Segregation of duties / authorisation levels to reduce fraud • Restricting access to assets (physical / information) • Password protection • Policies, standards, processes for planning
Contingency (Reactive)	Corrective – limits the scope for loss, reduced undesirable outcomes	• Policies, standards, processes to provide direction as to steps required in a certain situation • Budget review / reconciliation process • Performance review – budget-to-actual comparison to identify variance, Key Risk Indicators • Reporting • Inventories • Business Continuity / Disaster Recovery Plans • Whistleblowing / Fraud Detection
	Directive – direct activity to ensure a particular outcome is achieved	
	Detective – designed to identify occasions when undesirable outcomes have been realised	

5. Roles & Responsibilities

In a complex organisation, where risk is prevalent in day-to-day duties, it is vitally important that there is clear understanding of the roles and responsibilities involved in supporting implementation of a risk management framework. The table below intends to give an overview of these roles and responsibilities.

Table 5.1 Key Roles & Responsibilities of Risk Management

Group/Individual	**Responsibilities**
NHS Board	Provide oversight and scrutiny of NHS Forth Valley's risk management arrangements to seek assurance on their effectiveness Set risk appetite within NHS Forth Valley Approve the updates in regard to Strategic Risk
Chief Executive	To have overall accountability for the management of risk across NHS Forth Valley
Executive Leadership Team/ Senior Leadership Team	Set risk appetite within NHS Forth Valley Ensure risk management processes are supported to provide them with adequate information and assurance related to strategic and organisational risks

Audit & Risk Committee	To evaluate and recommend approval of the strategies and frameworks in respect of risk management to the NHS Board, and provide assurance on the effectiveness of the risk management arrangements, systems and processes To endorse updates and provide direction in respect of risks held within the strategic and organisational risk registers To review the organisation's risk culture and maturity and direct action in pursuit of continuous improvement in this area
Standing Assurance Committees	To ensure that an appropriate approach is in place to deal with their specified risks working within the NHS Forth Valley Risk Management Framework, and consider and endorse the assurance provided by the Executive Leadership Team and Senior Management regarding the effective management and escalation of risks
Head of Risk Management	Responsible for the implementation of the Risk Management Framework Ensure risks are properly identified, understood and managed across all levels within the organisation Report on the organisation's risk profile at Assurance and Audit Committees, FV NHS Board and other relevant organisational groups Oversee reporting to Directorates Periodically review the Risk Management Framework and arrangements, identifying areas for potential improvement Drive an improving risk culture through risk education, awareness and embedding into day-to-day management
Risk Owners	Accountable for ensuring the effective management of a risk, and providing assurance that key controls are operating effectively
Risk Lead	Responsible for managing risk on a day-to-day basis, assessing the risk score and updating the management plan, reviewing the risk on a regular basis and identifying sources and levels of assurance regarding control effectiveness, to allow risk owners to provide assurance
Risk Advocate	Responsible within an individual speciality, department or Directorate area for maintaining lines of communication with the risk function, administering the risk register and co-ordinating all risk activities

6. Governance

The section articulates the arrangements for communication, governance, and reporting requirements in relation to all risk activities. Establishing a clear and consistent approach to how and where risk information is communicated is fundamental to fostering a risk aware culture.

6.1 Risk Registers Hierarchy

Risks, once identified, are captured on risk registers. Each Department, Directorate & Division will hold a risk register for its area – the hierarchy of these is depicted below. There are five main levels of risk register, and an escalation route exists for risks that cannot be fully mitigated at the Department level. This is depicted in Diagram 6.1.1 Risk Register Hierarchy.

Diagram 6.1.1 Risk Register Hierarchy

Strategic Risk Register

Risks contained in the Strategic Risk Register are the high-level risks that could impact the delivery of longer-term strategic objectives of the organisation. Risks are not escalated/de-escalated from lower-level risk registers to the Strategic Risk Register automatically. Risk identification is through discussion at Board, Committee and Senior Leadership Team, horizon scanning discussions and through focused risk reviews. However, the identification of risk can come through any forum. At strategic level, the risk owner is the relevant Director/Chief Officer.

Organisational Risk Register

Risks contained in the Organisational Risk Register are top level, cross cutting risks that present a significant short-medium term threat to multiple Divisions or the Health and Social Care Partnerships (HSCPs). Risks are escalated and de-escalated via the Directorate and HSCP Risk Register(s). At Organisational level, the risk owner is the relevant Director/Chief Officer.

Divisional Risk Register

Each Division maintains a risk register comprising of the most significant risks identified from its respective Directorate Risk Registers. Risks are escalated to the Divisional Risk Register from the Directorate Risk Registers.

Directorate Risk Registers

Each Directorate holds a risk register that contains a cut of the most significant risks from its component Departments. Risks are escalated to the Directorate level via the individual Department Risk Registers. At Directorate Level, the risk owner is the relevant Head of Service/Department or equivalent.

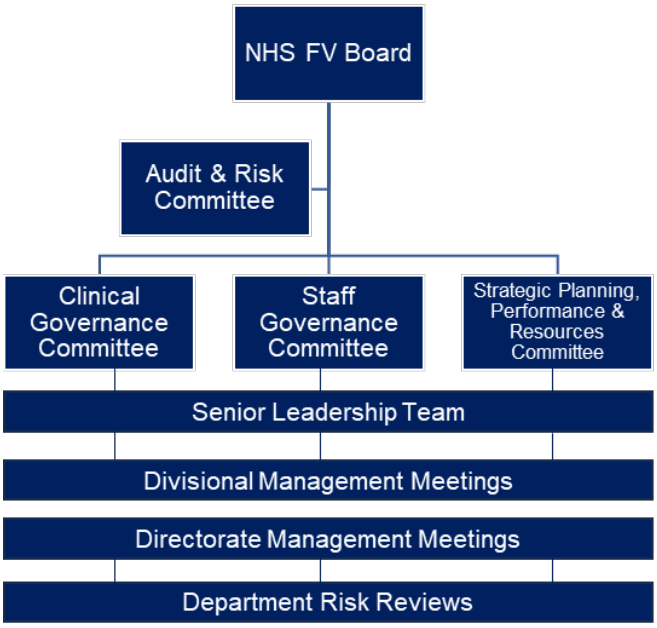
Department Risk Registers

Each Department will hold a risk register for its area – these form the bottom level of risk registers. At Departmental Level, the risk owner is the relevant team lead or operational manager.

6.2 Governance & Oversight

The Board of NHS Forth Valley is corporately responsible for the Risk Management Framework and for ensuring that significant risks are adequately controlled. To support the Board in discharging its responsibilities, the Standing Committees are responsible for various aspects of risk management. Principally these are the Audit and Risk Committee, Strategic Planning, Performance & Resources Committee, Clinical Governance Committee and Staff Governance Committee. All identified Standing Committees are responsible for providing assurance on the effective management of risks relevant to their area of responsibility. Additionally, the Audit and Risk Committee have a responsibility for overseeing the implementation of the Risk Management Framework, taking assurances from the Corporate Risk Management Team and the Senior Leadership Team. Diagram 6.2.1 illustrates NHS Forth Valley's risk management governance structure.

Diagram 6.2.1: Risk Management Governance Structure



6.3 Risk Management Performance Indicators

To enhance FV NHS Board's oversight of risk management, a set of Risk Management Performance Indicators have been established to demonstrate the application of the risk management framework throughout the organisation. Details of these indicators are provided in Appendix 1.

6.4 Integrated Risk Management: Health & Social Care Partnerships

In order to ensure strong risk management partnership arrangements, it is necessary to agree how emerging risks have an impact on more than one partner at a strategic level. Risks will be discussed and agreed across partners, with particular focus on:

- Where the risk was first identified
- Date of identification
- Nature of emerging risk
- Impact areas (e.g. service delivery, performance, strategic commissioning intentions etc)
- Mitigation required

Risks with the potential to impact more than one partner will be identified for inclusion in one or more of the following risk registers:

- NHS Forth Valley Strategic Risk Register or Organisational Risk Register
- Clackmannanshire and Stirling IJB Strategic Risk Register
- Falkirk IJB Strategic Risk Register

Any such emerging risks will be submitted to the NHS Forth Valley Senior Leadership Team to approve inclusion on the appropriate risk register.

Operational risks will continue to be managed by partner bodies, with relevant risk specialists working together to ensure consistent practice, aligning respective Risk Management Frameworks. The IJBs will also have a defined risk appetite to determine the target score range for Strategic Risks. It is recognised that partners may not have the same appetite, however these variances will be taken into consideration when the risks are being managed and reported.

Reciprocal assurances on the operation of the Risk Management arrangements and of the adequacy and effectiveness of key controls will be provided to/from partners. Receipt/provision of assurance will be facilitated by risk specialists from partner bodies, who will attend regular meetings to discuss risks and provide relevant advice.

7. Risk Appetite

In a complex organisation, like a healthcare system, it is important to articulate the thresholds for risk taking throughout the organisation. This ensures that there are clear expectations for behaviours regarding risk. The risk appetite process assists the organisation in identifying and describing these set thresholds. This is set and monitored by the NHS FV Board and will cascade throughout the rest of the organisation to inform local decision making.

The delivery of health services inherently has high risk and the concept of applying risk appetite can be challenging. However, if implemented effectively, particularly in a resource-finite environment, the process is a useful tool to avoid over or under management of risk. Deployed effectively, risk appetite can act as an enabler to the delivery of key services.

Risk appetite is therefore defined as the amount and type of risk we, as an organisation, aim to operate with in the pursuit of its strategies and objectives. Supplementing this, is the concept of risk tolerance, defined as the amount of risk that an organisation is willing to operate with. Providing a maximum threshold for risk taking behaviours throughout the Board.

There are four levels of appetite & tolerance, which are applied to the impact categories identified within NHS FV, are highlighted below in Table 2.9.1. Each of these levels also correlate to a section on the risk assessment table.

Table 2.9.1 NHS FV Risk Appetite/Tolerance Levels

Appetite Level	Description	Corresponding Risk Score
Averse	Very little appetite for this type of risk. Avoidance of risk and uncertainty is a key organisational objective. Exceptional circumstances are required for any acceptance of risk	1-3

Cautious	Minimal appetite for this type of risk. Preference for ultra-safe delivery options that have a low degree of inherent risk and only reward limited potential.	4-9
Moderate	Acceptance that a level of risk will be required to pursue objectives, or that a greater level of risk must be tolerated in this area. Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential reward.	10-16
Open	Acceptance that risk must be more actively taken in the pursuit of transformation or that a high level of risk must be tolerated. Willing to consider all potential delivery options and choose the one most likely to result in successful delivery while also providing an acceptable level of reward (and Value for Money). Eager to be innovative and confident in setting high level of risk appetite as controls are robust.	20-25

Further guidance on the application of risk appetite can be found in the 'NHS Forth Valley Risk Appetite Guide'. Appendix 2 details the overarching statement for Forth Valley's approved risk appetite levels. A summary statement of the defined appetite levels is included below in Table 2.9.2.

Table 2.9.2 NHS FV Risk Appetite Summary

Impact Category	Appetite Level	Tolerance Level	Target Score Range
Injury/Illness	Cautious	None	4-9
Service Delivery/Business Interruption	Cautious	None	4-9
Healthcare Experience	Cautious	Moderate	4-9
Workforce	Cautious	Moderate	4-9
Financial	Cautious	Moderate	4-9
Compliance	Cautious	Moderate	4-9
Public Confidence	Cautious	Moderate	4-9
Health Inequalities	Cautious	Moderate	4-9
Transformation & Innovation	Moderate	Open	12-16

To support ongoing management of risk and ensure that appetite is continually assessed in the risk process. It is important that risks are reviewed continuously. Each level of appetite has its own review timeline as noted below:

- In appetite – yearly review.
- In tolerance – quarterly review.
- Outside of appetite and tolerance - monthly review.

The risk owner is accountable for ensuring that risks are reviewed within these agreed timescales.

8. Communication

The risk management framework and underpinning procedural documents will be made available to colleagues to whom it applies via publication on NHS Forth Valley's Intranet.

In accordance with the Freedom of Information (Scotland) Act 2002, this Risk Management Framework will be published on NHS Forth Valley's external website.

9. Retention

The Risk Management Framework will be permanently retained in accordance with the relevant retention rules as set out within NHS Forth Valley's Record Retention Schedule. This is to ensure that a record is maintained of what was in force at any given time should they be required for purposes of audit or litigation.

Relevant EQIA documentation will also be retained with the documents to demonstrate due process was followed.

Previous versions may also provide key evidence of document development or be retained for reference purposes. Once superseded, the risk management framework will be deposited with Stirling University Archives as a public record in accordance with the Public Records (Scotland) Act 2011.

10. Support and Advice

For risk management advice contact the Corporate Risk Management Team on:

E-mail: fv.corporateriskmanagement@nhs.scot

11. Alternative Formats

NHS Forth Valley is happy to consider requests for publications in other language or formats such as large print. To request this document be made available in another language, please contact 01324 590886.

To request this document be made available in another format, please contact:

Phone: 01324 590886 **Text:** 07990 690605 **Email:** FV.interpretation@nhs.scot

12. Appendix 1 – Risk Management Performance Indicators

Descriptor	Indicator	Nominator	Denominator	Frequency & By Whom	Rationale
Risk Profile	% of risks within appetite reviewed 6 monthly.	No. of risks in appetite in specified area which have been reviewed every 6 months.	Total number of risks in appetite in specified area.	Monthly by the Corporate Risk Management Team.	This will provide an indication of the risks that are managed well.
	% of risks within tolerance reviewed every two months.	No. of risks in tolerance in specified area which have been reviewed every two months.	Total number of risks in tolerance in specified area.	Monthly by the Corporate Risk Management Team.	This will provide an indication of the risks that will become a bigger problem if not mitigated timeously.
	% of risks out with appetite & tolerance reviewed monthly.	No. of risks out with appetite & tolerance in specified area which have been reviewed monthly.	Total number of risks out of appetite/tolerance in specified area.	Monthly by the Corporate Risk Management Team.	This will provide an indication of the number of risks that are creating significant exposure to the organisation.
	% of risks reviewed in timeframe established.	Total no. Of risks reviewed in appropriate timeline.	Total number of risks in specified area.	Monthly by the Corporate Risk Management Team.	This will provide an overview of how well we are complying with the risk framework.
	Number of unknown risks.	-	-	Monthly by the Corporate Risk Management Team.	This will provide an overview of how many risks in are logged in the system without any information.
Risk Mitigation	% of risks with defined action plans.	Total number of risks out with the Boards appetite level for the service area with actions linked.	Total number of risks out with the Boards appetite and tolerance for the service area.	Monthly by the Corporate Risk Management Team.	To provide assurance that the risks identified have a defined action plan against them.
	% of actions that are overdue.	No. of overdue actions in specified area.	No. of total risk actions in specified area.	Monthly by the Corporate Risk Management Team.	This will provide an indication to the status of our further mitigating actions.
	Total Number of Controls Listed	-	-	Monthly by the Corporate Risk Management Team	This will provide an indication of the number of controls live in the system.
Risk Training	No. of staff members that have completed level 1 training.	-	-	Monthly by the Performance Team – TURAS Extract.	This will give an indication as to who is aware of Corporate Risk and who the Risk Team are.
	No. of staff members that have completed level 2 training.	-	-	Monthly by the Performance Team – TURAS Extract.	This will give an indication of how many staff members have completed our in-depth risk management training.
	No. of staff members that have completed the Pentana Risk Management training.	-	-	Monthly by the Performance Team – TURAS Extract.	This will give an indication of how many staff members have completed our system training.

Appendix 2 – Risk Appetite Statement

Definitions	Description	Identifier of Agreed Level (Corresponding Colour)
Risk Appetite	Risk appetite refers to the amount and type of risk that an organisation is willing to accept in the pursuit of its objectives.	
Risk Tolerance	Risk tolerance is the maximum level of risk an organisation can tolerate regarding each type of risk before it is significantly impacted.	

Appetite Level	Averse	Cautious	Moderate	Open
Impact Category / Risk Score	**LOW (1-3)**	**MEDIUM (4-9)**	**HIGH (10-16)**	**VERY HIGH (20-25)**
Injury/Illness	NHS FV are not willing to accept any risks which impact on the physical and psychological safety of a patient, staff member or visitor and are unwilling to take any risks which could improve patient, staff and visitor physical and psychological safety.	NHS FV is willing to take minimal levels of risk when it could impact on staff, patients or visitors and are prepared to take minimal risk which could improve patient, staff and visitor physical and psychological safety.	NHS FV are willing to accept a high exposure to risks which could negatively impact on the physical and psychological safety of a patient, staff or visitor or FV and are willing to take a high level of risk which could improve patient, staff and visitor physical and psychological safety.	NHS FV are willing to accept will accept significant degrees of risk which could negatively impact on our patients, visitors and staff, and will take significant levels of risk which could improve patient, staff member and visitor outcomes.
Healthcare Experience	NHS FV are not willing to accept any risk which negatively impacts on the stakeholder's experience within NHS FV and will not take any risk which may positively impact on the stakeholder's experience of NHS FV.	NHS FV are willing to accept a minimal level of risk which could negatively impact on the stakeholder's experience of NHS FV and are willing to take a minimal level of risk which could positively impact on the stakeholder's experience of NHS FV.	NHS FV are prepared to operate with a high exposure to risks which could negatively impact on the stakeholder's experience of NHS FV and are willing to take a high level of risk which could positively impact on the stakeholder's experience of NHS FV.	NHS FV will accept significant levels of risk which could negatively impact on the stakeholder's experience of NHS FV and will take significant levels of risk which may positively impact on the stakeholder's experience of NHS FV.
Transformation/ Innovation	NHS FV are unwilling to accept any risk which will impact negatively on the ability to deliver Transformation/Innovation and are unwilling to take any risk which could positively impact delivery of Transformation/Innovation.	NHS FV are willing to accept a minimal level of risk which could impact on our ability to deliver Transformation/Innovation and are willing to take a minimal level of risk which could positively impact on the delivery of Transformation/Innovation.	NHS FV are prepared to operate with a high exposure to risks which could impact on our ability to deliver Transformation/Innovation and are willing to take a high level of risk which could positively impact on the delivery of Transformation/Innovation.	NHS FV are willing to accept significant levels of risk that could negatively impact on the delivery of Transformation/Innovation and are willing to take significant degrees of risk which could positively impact the delivery of Transformation/Innovation.
Service Delivery / Business Interruption	NHS FV are unwilling to accept any risk which negatively impacts on the ability to deliver services and are unwilling to take any risk which could improve service delivery.	NHS FV are willing to accept a minimal level of risk which could impact on our ability to deliver services and are willing to take a minimal level of risk which could improve service delivery.	NHS FV are prepared to operate with a high exposure to risks which could impact on our ability to deliver services and are willing to take a high level of risk which could improve service delivery.	NHS FV are willing to accept significant levels of risk which will negatively impact on service delivery and are willing take significant levels of uncertainty which could improve service delivery.
Workforce	NHS FV are unwilling to accept any risk that could negatively impact on recruitment and retention of a confident, flexible and trained workforce and are unwilling to take any risk that could positively impact on recruitment and retention of a confident, flexible and trained workforce.	NHS FV are willing to accept a minimal level of risk which could negatively impact on recruitment and retention of a confident, flexible, trained workforce and are willing to take a minimal level of risk which could positively impact our ability to improve recruitment and retention of confident, flexible, trained workforce.	NHS FV are prepared to operate with a high exposure to risks which could negatively impact on recruitment and retention of a confident, flexible, trained workforce and are willing to take a high level of risk which could positively impact our ability to improve recruitment and retention of confident, flexible, trained workforce.	NHS FV are willing to accept significant degrees of risk that could negatively impact on recruitment and retention of a confident, flexible and trained workforce and are willing to take significant degrees of risk which may positively impact on our ability to recruit and retain a confident, flexible and trained workforce.
Financial	NHS FV are unwilling to accept any risk that could negatively impact on budget performance and are unwilling to take any risk that could positively impact budget performance.	NHS FV are willing to accept a minimal level of risk which could negatively impact on budget performance and external compliance requirements and are willing to take a minimal level of risk which could positively impact on budget performance.	NHS FV are prepared to operate with a high exposure to risks which could negatively impact on budget performance and are willing to take a high level of risk which could positively impact on budget performance.	NHS FV are willing to accept significant degrees of risk that could negatively impact on budget performance and are willing to take significant degrees of risk which may positively impact on budget performance.
Compliance	NHS FV is unwilling to accept any risk that could negatively impact on compliance with internal and external requirements and are unwilling to take any risk that could positively impact on compliance with internal and external requirements.	NHS FV are willing to accept a minimal level of risk which could impact compliance with internal and external requirements and are willing to take a minimal level of risk which could positively impact on compliance with internal and external requirement.	NHS FV are prepared to operate with a high exposure to risks which could negatively impact on compliance with internal and external requirements and are willing to take a high level of risk which could enhance our compliance with internal and external requirements.	NHS FV are willing to accept significant degrees of risk that could negatively impact on compliance with internal and external requirements and are willing to take significant degrees of risk which may positively impact on compliance with internal and external requirements.
Public Confidence	NHS FV are unwilling to accept risks that could negatively impact on the public perception and confidence of the organisation and are unwilling to take any risk that could positively impact on the public perception and confidence of the organisation.	NHS FV are willing to accept a minimal level of risk which could impact on our public perception and confidence of the organisation and are willing to take a minimal level of risk which could positively impact on the public perception and confidence of the organisation.	NHS FV are prepared to operate with a high exposure to risks which could negatively impact on public confidence and are willing to take a high level of risk which could enhance our public, where the benefit of the decision outweighs the impact of this risk.	NHS FV is willing to accept significant degrees of risk that could negatively impact on our public perception and confidence and is willing to take significant degrees of risk which may positively impact on our ability enhance our public perception and confidence.
Health Inequalities	NHS FV are unwilling to accept risks that could negatively impact the Health Inequalities within FV and are unwilling to take any risk that could reduce Health Inequalities within FV.	NHS FV are willing to accept a minimal level of risk which could impact on Health Inequalities within FV and are willing to take a minimal level of risk which could reduce Health Inequalities within FV.	NHS FV are prepared to operate with a high exposure to risks which could negatively impact on Health Inequalities within FV and are willing to operate with a high exposure to risks which could reduce Health Inequalities within FV.	NHS FV are willing to accept significant degrees of risk that could negatively impact on Health Inequalities within FV and are willing to take significant degrees of risk which may reduce Health Inequalities within FV.

The below table details the rationale for identifying the risk appetite levels for NHS Forth Valley.

Impact Category	Appetite Level	Tolerance Level	Rationale for Level
Injury/Illness	Cautious	None	NHS Forth Valley exists to deliver safe, effective, person-centred care to its population, and provide a safe environment for patients, staff and the public. We recognise that to meet patient care objectives and to deliver a safe service, where the benefit exceeds the risk, there are occasions where we must operate with a **cautious** appetite for risks which could result in Injury/Illness.
Healthcare Experience	Cautious	Moderate	NHS Forth Valley has a sustained focus on improving care and experience of patients, families, and carers. We have a **cautious** appetite for risk impacting on the healthcare experience, reflecting our desire for positive patient experience and quality clinical outcomes, but recognising that it is not possible to avoid all risk and uncertainty in this area.
Transformation/ Innovation	Moderate	Open	NHS Forth Valley has a **moderate** appetite for innovation, accepting that a greater degree of risk is required to maximise innovation and opportunities to improve patient experiences and outcomes, transform services and ensure value for money.
Service Delivery / Business Interruption	Cautious	None	NHS Forth Valley has a **cautious** appetite for risks which could result in Service/Business Interruption. Delivery of Health and Social Care is a priority, and while it may not be possible to eliminate risk, there is a focus on ensuring that essential health and social care needs are met quickly and effectively.
Workforce	Cautious	Moderate	NHS Forth Valley will operate with a **cautious** appetite. The priority will remain adherence to professional standards, and staff should continue to work within the limits of their competence, exercise “duty of candour” and raise concerns when they come across situations that put patients or public at risk.
Financial	Cautious	Moderate	NHS Forth Valley’s strategic aim is high quality and sustainable clinical services. We wish to achieve financial sustainability by spending well and making the most of our resources. Therefore, we have a **cautious** appetite for financial risk as budgets are constrained and unplanned / unmanaged budget variance could affect our ability to achieve statutory financial targets, potentially increases reputational risk and places pressure on divisions and departments. Well informed risks can be taken but budget variances are to be minimised and value for money is the primary concern.
Compliance	Cautious	Moderate	NHS Forth Valley has a **cautious** appetite for risks impacting on Inspection/Audit. We are prepared to take informed risks which could result in recommendations, improvement notices or criticism, provided that the benefit outweighs the negative outcome.
Public Confidence	Cautious	Moderate	NHS Forth Valley has a **cautious** appetite for risks impacting on public confidence which flow from informed decision-making, in order that achievement of strategic objectives is not hindered.
Health Inequalities	Cautious	Moderate	NHS Forth Valley has a **cautious** appetite as there is a need to take a degree of balanced risk to achieve potential rewards from undertaking cost effective prevention activities and addressing health inequalities. We are focused on reducing healthcare generated inequalities.

NHS Forth Valley

Forth Valley NHS Board

10. Communications Update for 2025/26 and Key Plans and Priorities for 2026/27

Purpose: This report is for Decision

Executive Sponsor: Kevin Reith, Director of People

Author: Elsbeth Campbell, Head of Communications

Executive Summary

This paper provides an update on communications activity undertaken during 2025/26 and an overview of key plans and priorities for 2026-27 to further strengthen and improve corporate communications across the organisation.

Action Required

The Forth Valley NHS Board is asked to:

(1) note the update on communications activities undertaken during 2025/26

(2) approve outline communication plans and priorities for 2026/27

(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

Communication plans and priorities for 2025/26 were approved by the NHS Board at its meeting on 25 March 2025 and proposals for 2026/27 were discussed at the SLT meeting on 30 March 2026.

Risk Assessment and Mitigation

Effective communications play a vital role in educating, informing and reassuring local patients and members of the public who use our services. Honest, open and timely communications are also important to ensure staff are kept informed on any changes or issues which affect them, and that media receive the information they require to help achieve accurate, fair and balanced coverage.

If NHS Forth Valley's communication plans and priorities are not aligned to strategic plans and priorities and do not respond to the changing needs of staff, patients, media and the public this could damage the organisation's reputation and credibility. This could result in a loss of trust and confidence, reduce uptake and engagement with local services and adversely impact on the experience of local patients and staff.

Ongoing development, support and advice provided by the Communications Department, working collaboratively with services, teams and departments across the organisation will help address many of these risks. However, it is important to recognise that communications, in the wider context, is everyone's responsibility and meaningful change and improvement can only be achieved with the support and engagement of service and clinical leads across the organisation.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty
Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial, Digital and Infrastructure Implications
Taking a digital first approach for the majority of patient information will reduce printing costs, avoid waste and provide more accessible information which can be accessed 24/7. Online information can also be quickly updated to reflect any changes to guidance or contact details and hosting more information and advice online will help prepare services for the roll out of the MyCare.scot app.

The Communications Department has been proactive in the use of new tools and technology, for example designing and building a staff intranet on SharePoint, and there is scope to use Office 365 resources to further enhance and improve communications, collaboration and information sharing across the organisation.

While some of the developments highlighted in this report can be take forward by the Communications Department, a number require support from colleagues in other areas, including IT and e-health, HR and OD, as well as clinical colleagues working across primary and secondary care.

Workforce Implications
While it is recognised that it takes time and commitment to communicate effectively, sharing and supporting a two-way flow of information and feedback has many positive benefits for local services and can lead to a more engaged, productive and committed workforce who feel valued and listened to. As part of the Culture Change and Compassionate Leadership Programme work has been undertaken to explore ways to improve all forms of communication across the organisation. There are plans to build on this work through a range of planned activities, including more guidance for managers as well as a number of OD and training initiatives.

The Communications Department is a small team which is dealing with a growing, diverse and increasingly complex workload. There is therefore a need to continually assess the level of staffing and resources required and explore how the Department can best provide expert advice, support and tools to enable communications to be owned by all staff across the organisation.

Quality / Patient Care Implications
Effective communication across NHS services is essential for improving patient safety, enhancing experience, and fostering better teamwork, directly leading to better health outcomes and reduced operational risk.

Corporate Communications play a vital role in managing organisational reputation, coordinating communication with staff, patients and the public, and promoting a wide range of health services and initiatives. This is achieved through strategic communications, media relations, managing digital content across websites, staff intranet and social media channels, internal communications, stakeholder and public engagement.

Population Health & Care Strategy
Effective communication across local healthcare services is essential for improving patient safety, enhancing experience, and fostering better teamwork, directly leading to better health outcomes and reduced operational risk.

The Communications Department plays a vital role in managing communications with staff, patients and the public, raising awareness of local health services and support and sharing key health information and advice. This is achieved through corporate communications, media relations, managing digital content across websites and social media channels, internal communications and stakeholder engagement.

Climate Change / Sustainability Implications
Taking a digital first approach for patient information will reduce waste by avoiding unnecessary printing and the requirement to dispose of out-of-date material.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒
If yes, please provide details.

A series of meetings are planned with Directorate and Professional leads to discuss communications, gather feedback and identify opportunities for closer working going forward. There are also plans to carry out a staff survey to capture feedback and suggestions from staff across the organisation. This will inform the development of an updated Communications Framework.

Appendices
Appendix 1 - Communications Update for 2025/26 and Key Plans and Priorities for 2026/27

Communications Update for 2025/26 and Summary of Key Priorities for 2026/27

Background

A summary of key communications plans taken forward during 2025/26 are outlined below along with details of key communications priorities for 2026/27.

Main Considerations

Key Issues to be considered:

- The pre-election period ends on 7 May 2026 which will enable local and national communications and marketing activity to resume as normal.
- Communications plans will be reviewed and adapted throughout the year to take account of any new local or national service developments, policies and priorities.

Communications Plans and Priorities - 2025/26
Summary of Key Activities

NHS Reform – a wide range of communications activities were undertaken to highlight how NHS Forth Valley met or addressed a number of national priorities for 2025/26 set out by the Scottish Government to protect, strengthen and renew services across NHS Scotland.

This included work to:

- Highlight a new local project which aims to shift the balance of care, free up inpatient capacity and ensure more people are able to remain in their own homes rather than been transferred direct from hospital to a care home.
- Deliver a share of 150,000 additional appointments and procedures, supported by increased National Treatment Centre activity. Work was undertaken to highlight efforts to reduce waiting times for local patients as well as provide mutual aid to a number of patients from other NHS Boards.
- Introduce a new Rapid Cancer Diagnostic service for patients with non-specific symptoms of cancer who do not meet the referral criteria for other suspected cancer pathways. The service was launched at Forth Valley Royal Hospital on 2 May 2025. Neil Gray, the Cabinet Secretary for Health and Social Care, Neil Gray, visited the service on 6 August 2025 to unveil updated national referral guidelines for suspected cancer and heard from staff how local patients are already benefiting from the new service.
- Provide access to a Frailty team in our Emergency Department by Summer 2025. A new 23 bed Frailty Unit opened A new 23 bed Frailty Unit opened in the Acute Assessment Unit at Forth Valley Royal Hospital on 9 June 2025.
- Showcase the work of our Hospital at Home service. The First Minister visited the service on 9 July 2025 to meet with staff and hear more about local expansion plans. During the visit he also announced additional investment to expand the service across Scotland, including £4.4m for NHS Forth Valley.
- Highlight the impact of a Single Point of Contact (SPOC) service which provides dedicated support to patients with cancer throughout their treatment journey. During a visit to meet the local team providing the service in NHS Forth Valley on 12 March 2026, Neil Gray, Cabinet Secretary for Health and Social Care, announced plans to expand the service across Scotland.

Other **service developments and improvements** highlighted during the year, included:

- The local launch of a Macmillan Cancer Support service offering people living with cancer and their families emotional, practical and financial support. The integrated health and social care approach creates a single, coordinated service that combines clinical pathways and tailored, non-clinical support for people affected by cancer.
- The launch of a new service to help speed up lung cancer diagnosis **–** the Rapid on Site Evaluation (ROSE) service helps ensure samples are of the quality required to make a clear diagnosis and that enough material is collected for genetic testing. The result is faster diagnoses, quicker lab results and earlier discussion to agree the best treatment plans for local patients.
- A study on a new local Breast Cancer Assessment Pathway which showed the new arrangements can ease pressure on GP practices and prevent delays in diagnosis.
- The approval of a Business Case to introduce robotic assisted surgery in NHS Forth Valley. This will enable local staff to deliver high-quality complex surgery closer to home, improve outcomes for patients undergoing cancer treatment, and strengthen the Board's ability to recruit, retain and train skilled staff.

Population Heath and Care Strategy – a wide range of communications and engagement activity work was undertaken to support the development and publication of NHS Forth Valley's new Population Health and Care Strategy. This included an extensive programme of awareness raising and engagement over Spring and Summer 2025 to capture feedback on the draft strategy from a wide range of stakeholders. This feedback informed the development and design of the final strategy which was launched on 30 Sept 2025 alongside a summary version and new Strategy section on the NHS Forth Valley website.

Culture Change and Compassionate Leadership Programme (CCCL) – work continued to promote, encourage participation and highlight progress in the delivery of the CCCL programme. This included the development and of 8 workstreams which reflected the key themes and priorities identified from the extensive engagement with staff, students and partners over the previous 18 months. Regular updates on the workstreams were shared throughout the year along with details of opportunities for local staff and teams to find out more and get involved through online sessions, events and workshops. In recognition of the further progress that had been made to strengthen and improve leadership, culture, and governance across the organisation, NHS Forth Valley was de-escalated to Stage 2 of the NHS Scotland Support and Intervention Framework on 9 October 2025.

Value Based Health and Care – work was taken forward with local leads to raise awareness of Value Based Health and Care across the organisation. This approach, aims to ensure we make the best use of the resources available to improve the health of all local people, achieve better outcomes for patients and deliver sustainable health services. Communication plans were developed to support the rollout of the programme across the organisation. This included the development of a dedicated portal on the Staff Intranet, a First Steps guide for local teams and the launch of a new Value Based Health and Care Collaborative in January 2026, the first of its kind in Scotland.

Climate Change and Sustainability – work continued to highlight ongoing efforts to reduce energy use, harmful emissions and waste across NHS Forth Valley as part of wider efforts to respond to climate change. This included work a lean surgical trays initiative in theatres to remove unnecessary items, reduce waste and ease pressure on decontamination services. Work is also underway within endoscopy services to reduce single-use plastics, improve the management of clinical waste and reduce energy consumption associated with endoscopic procedures. These initiatives, which form part of a national programme led by Green Healthcare Scotland, have been recognised as examples of best practice which are now being applied by other NHS Boards.

Equality and Inclusion – a range of activities were undertaken during 2025/25 to highlight NHS Forth Valley's commitment to equality and inclusion. This included the launch of a new Equality and Inclusion Strategic Framework in April 2025 which sets out key plans, priorities and outcomes for 2025 – 2029, the publication of a Joint Statement from Falkirk Community Planning Partnership in January 2026 to reinforce the commitment of all partners to challenge prejudice wherever it exists and the launch of a new plan to tackle racism which sets out the Board's clear commitment to identify and challenge racism wherever it exists and drive meaningful change to ensure equality, dignity and respect for all patients, staff and visitors.

National Treatment Centre (NTC) – work continued with Forth Health, the contractor, NHS Scotland Assure and Falkirk Council to address the remaining outstanding technical issues relating to the pipework and fire compliance regulations for the new NTC inpatient ward. The Communications Department worked with local leads to provide updates on this work and respond to a number of media enquiries throughout the year. These, emphasised, that interim arrangements that have been put in place to ensure that patients from other health board areas continue to access treatment within a dedicated ward area at Forth Valley Royal Hospital.

Patient Hub – work was undertaken to support the roll out of a new online system which enables local patients to manage appointments, keep in touch and complete any questionnaires or forms online, prior to attending their appointments. This included providing advice and guidance on the content and format of patient communications, providing electronic versions of patient leaflets which can be uploaded onto the Patient Hub platform. Work also began to explore how this development ties in national plans to roll out a new Health and Social Care app across NHS Scotland (MyCare.scot).

Prison Healthcare – work was undertaken to highlight ongoing work to develop and improve healthcare services and support in all three national prisons in the Forth Valley area. This included highlighting the findings of an inspection at HMP Glenochil where health and wellbeing services and support received the top rating of Good. The Communications Department also worked with Scottish Prison Service colleagues to organise filming with prison healthcare staff for a number of projects. These included a BBC Scotland series Jailed: Women in Prison which was filmed at HMP/YOI Stirling and HMP Grampian, and an STV news feature highlighting the challenges of caring for older prisoners with complex health and care needs.

Non-Executive recruitment – communication plans were developed and implemented to support the successful recruitment of three new Non-Executive Board members whose appointments were confirmed on 16 July 2025. Work was also undertaken to support the recruitment of a permanent Chair and Neena Mahal was appointed to this role by the Cabinet Secretary for Health and Care on 10 September 2025.

Patient and Staff Stories – work was taken forward throughout 2025/26 to highlight a number of patient and staff stories which were shown at Board meetings and shared on NHS Forth Valley's website and YouTube channel. This included features on local patients who had benefited from Organ Donation including Lisa Hertwig from Alloa who has received lung and kidney transplants. A wide range of service developments, awards and achievements were also promoted during the year. These included the Neonatal Unit achieving Gold Accreditation for the outstanding care and support it provides to babies and their families, the Myeloma UK Clinical Service Excellence Programme Award presented to oncology staff in recognition of their outstanding care and dedication to people with myeloma and the work of local audiology staff who celebrated 20 years of providing a hearing screening service for newborn babies. The George Cross medal was also displayed for the first time at Forth Valley Royal Hospital in November 2025**.** Presented to the four National Health Services of the United Kingdom, the medal recognises over 70 years of NHS service and the extraordinary response of NHS staff across the country to the Covid-19 pandemic.

Digital developments – a number of digital forms have been created for staff to make it easier and quicker for staff to submit HR, payroll and financial information. Online referral forms have also been introduced for weight management services to enable people to refer directly to the service for advice and support. Efforts continued to maintain and build NHS Forth Valley's social media presence on existing social media channels as well as developing a presence on a number of new platforms.

Research – the Communications Department worked closely with Research and Development colleagues to promote a wide range of research work. This included a Groundbreaking Lung Cancer Trial where NHS Forth Valley was the first unit in Europe to open a new clinical trial on treatments advanced and recurrent lung cancer, participation in a new Network which brings together a number of NHS Boards, universities and charities, carers and community organisations to focus on how technology can enhance and support the social, mental and physical capabilities of people living with dementia and a new research trial which aims to give local patients access to an innovative new treatment for psoriatic arthritis which affects around 1 in 4 people with the skin condition psoriasis. Work was also undertaken to highlight local research activity and staff across NHS Forth Valley as part of Red4Research day on 20 June 2025.

Forth Valley University College NHS Partnership – a wide range of work was undertaken in partnership with the University of Stirling and Forth Valley College to promote new training and development opportunities. This included: -

- A new collaboration with University of Pennsylvania's School of Nursing, one of the top nursing schools in the world, to help drive forward further innovative work to improve patient care, address healthcare challenges and enhance the profession of nursing.

- Additional funding to develop a Fast Track to nursing course which enables more people of all ages to access nurse training and support.
- New healthcare training programmes for young people – including the Pathways to Healthcare Careers programme, which provides **practical work experience** and classroom-based learning to prepare young people for a range of healthcare careers, and Project SEARCH – a supported internship for young people with learning disabilities or autism.
- The successful recruitment of 150 graduate nurses who have been offered permanent contracts in local hospital, mental health and community services across NHS Forth Valley.
- A celebration event to recognise local nurse mentors - The Inspirational Practice Supervisor/Assessor Celebration event recognises the vital role nurse supervisors and assessors play in mentoring **students during their clinical placements.**
- Honorary appointments for local NHS Forth Valley staff which were confirmed in December 2025 and March 2026 by the University of Stirling.

In addition, a wide range of employability initiatives were highlighted during the year to encourage more people to consider a career in health and care. These included recruitment fayres, events with local schools as well as a range of training and development opportunities.

Key Communications Plans and Priorities for 2026/27

Priority	Key Actions	Background
External Communications		
Patient Information	Work with services across the organisation to take a digital first approach to patient information. This will reduce printing costs, avoid waste and provide more accessible information which can be viewed and translated online 24/7. Arrange for hard copies to be printed off from the NHS Forth Valley website when requested or required or emailed direct to a patient or family member.	Many services still print and post thousands of patient information leaflets with appointment letters every year. However, the latest Ofcom Online Nation Report shows that 95% of the 16+ population now have access to the internet at home with smartphones accounting for the majority of online use (75% +). It is recognised that, while only the minority of adults (5%) do not have internet access at home (down from 7% in 2022–23). Online information can also be quickly updated to reflect any changes to guidance or contact details and will also help prepare services for the roll out of the new national MyCare.scot app.
Website development	Develop new websites for the;- **Staff Bank** to help share information and streamline local processes. **Bairns' Hoose** initiative which will offer support to children who have been victims or witnesses of abuse, as well as those under the age of criminal responsibility whose behaviour has caused harm.	The Communications Department currently manages 10 websites (including the main NHS Forth Valley website, the Scottish Centre for Simulation & Clinical Human Factors (SCSCHF) , Forth Valley Medical Education, Clacks and Stirling HSCP, Falkirk Health and Social Care Partnership Central Sexual Health, Forth Valley University College NHS Partnership, Community Pharmacies, Travel Health Service and Staff News)**.** The NHS Forth Valley website is the primary source of information and first point of contact for patients and visitors with 2.8m visits annually (233,000 a month).

	National Treatment Centre – **Forth Valley** once the inpatient ward is operational (similar to content developed for other NTCs). Develop new online direct referral forms, including one for Podiatry Services, building on the success of the direct referral arrangements for the Weight Management service. Review effectiveness of new automated review process introduced to prompt service leads to review relevant website content on a regular basis.	The home page will continue to be used to highlight key health messages and campaigns along with the Info Zone which is updated to provide tailored information and advice, including details of services available during public holidays.
Roll out of Patient Hub/Digital Front Door (MyCare.scot)	Continue to work with IT and e-Health leads on the rollout of Patient Hub across local health services. Work with Health Records to create electronic versions of patient information which can be uploaded direct on to the portal until these can be replaced with direct web links. Share relevant information and updates on whole population availability with local stakeholders in April 2026 (including staff, GPs and pharmacists) ahead of a wider national awareness campaign later in the year.	Patient Hub continues to be rolled out to a wide range of services across NHS Forth Valley to enables patients to access appointment inform, along with other relevant information, to be shared electronically. The Scottish Government is also rolling out MyCare.scot – a new digital platform which can be used to access health and care information online. The service is currently being piloted to offer appointments to dermatology patients in NHS Lanarkshire. However, there are plans to roll out the use of MyCare.scot for digital appointments to all NHS Boards over the next two years. Access to MyCare.scot was widened out across Scotland from 15 April 2026 to enable people to view basic health information. This includes details of an individual's Community Health Index (CHI) number, current medications and known allergies, vaccination records and information on local health and care services (via links to NHS Inform).
Media Management	Promote a wide range of service developments and improvements including:-	The Communications Department works closely with local and national media to respond to a wide range of media enquiries as well as filming and interview requests. The Department also

	• Introduction of robotic surgery – following approval of the Business Case to introduce robotic surgery in February 2026, work was undertaken to highlight the delivery and installation of the new Da Vinci XI dual-console robotic system at Forth Valley Royal Hospital on 26 March 2026. Surgical and theatre staff are now undertaking detailed training with the aim of treating the first patients in Summer 2026. • Opening of new GP walk in clinics in Clackmannanshire (and possibly Falkirk) • Updates on National Treatment Centre inpatient ward • Extension of Long Covid service to include ME/CFS and some other related conditions. • Introduction of new ECG patch monitoring arrangements Continue to work closely with local and national media and develop closer links with reporters from the Dunfermline Press and Central Fife who now manage the Alloa Advertiser, as well as The Courier which has expanded their editorial coverage to the Stirling area.	proactively identifies potential promotional opportunities, case studies, news and feature stories to promote the work of local staff and services. Wherever possible, links with Value Based Health and Care and the aims of our Population Health and Care Strategy will be referenced to raise awareness and highlight progress.
Social media	Focus efforts on Facebook and Instagram (where we have far more engagement and reach) and develop NHS Forth Valley's presence on LinkedIn and Bluesky. Create more animated graphics to help highlight key messages and develop pre-recorded video clips to highlight key themes or issues.	The Communications Department currently manages the following six social media channels • Facebook • Instagram • YouTube • LinkedIn • Bluesky • X (formerly Twitter)

	Review and update the Board's Social Media Policy to ensure if reflects current guidance and best practice as well as addressing some of the common issues relating to the use of social media by staff, patients and members of the public.	While there is little engagement on X due to the change in algorithms, the plan is to retain a presence as a secondary channel. This approach, which is similar to that being taken by other NHS Boards and public sector organisations, enables the Board to: - • reach the public and patients quickly in emergencies • correct and challenge misleading or inaccurate information • retain control of our account name on X • maintain access to a platform that is still widely used • by media, partner organisations and other key stakeholders
e-bulletin	Continue efforts to promote and encourage people to sign up to the monthly NHS Forth Valley ebulletin to increase the mailing list size and reach.	The Communications Department issues a monthly e-bulletin to a dynamic list of people who have signed up to receive regular news and updates. This is helpful tool to share information and updates, including invites to local meetings and events, as well as seek feedback on specific issues.
Internal Communications		
Culture Change & Compassionate Leadership Programme	Provide updates on work completed to date and highlight plans to mainstream this work going forward and reassurance that this remains a key organisational priority. This includes plans to: - • Support the **Living our Values** workstream through the develop of core templates and resources to support consistency of messaging as well as ongoing work to increase visibility and engagement through staff stories, case studies	A range of activity and updates will be reported to the Strategic Workforce Programme Board.

	and feedback. • Include communications information and advice as part of the new **staff induction** process. • Develop a short **Communications Guide for Managers** on the tools and resources currently available, relevant communication policies, along with guidance and examples of best practice to help embed good communications within local teams, wards and services across the organisation.	
Value Based Health and Care	Continue work to raise awareness of Value Based Health and Care across the organisation. This will include: - • Highlighting the work of the new Value Based Health and Care Collaborative • Sharing examples of progress and best practice. • Raising awareness of local resources, training and engagement opportunities.	
Staff Engagement	Carry out a staff survey to gather feedback on current communications approaches and tools to identify what is working well along with ideas and suggestions for further developments and improvements, particularly in relation to internal communications.	Feedback from the survey will inform future planned developments and the refresh of existing Communications Framework.

	Meet with senior leadership teams across the organisation to discuss opportunities to strengthen links with local teams to improve two-way communications. Explore the development of a communications network to help develop closer links, share updates on service developments, achievements and identify potential staff and patient stories.	
Digital developments	Continue to develop, expand and improve information and resources on the Staff Intranet. This includes: - • The development of a new Finance Hub • Ongoing redevelopment of the Learning Zone • Management Referral Guidelines (MARG) • Staff Support and Staff Communities Continue to with eHealth, HR, Finance and ICT colleagues to explore opportunities to further streamline online content and frequently used forms. Work is underway with the e-health and ICT teams to explore opportunities to enable the Communications Department to add messages to the start-up screen on all work PCs and laptops.	A new automated review and escalation process has been put in place to ensure that content is regularly reviewed. Arrangements are in place to give health and social care staff out-with NHS Forth Valley (including council employees and healthcare students) access to the Staff Intranet, where required. A number of digital forms have been introduced to make it easier and quicker for staff to submit information. This could be used to share key updates on issues relevant to all staff (e.g. staff vaccinations, iMatter survey, Staff Awards etc). Several other NHS Boards use this as another vehicle to highlight key information and share updates with local staff.
NHS Scotland Brand Guidelines	Raise awareness of updated NHS Scotland brand guidelines. Update existing logos and templates to reflect new guidance.	This includes updated guidance on brand identity, logo sizing, positioning and exclusion zones, approved colours and fonts for NHS Forth Valley.

	Work with service and professional leads across the organisation to ensure compliance	The guidance also highlights that it is not permissible for NHS Boards to create or use separate sub-identities for individual directorate, division, department, team, service or initiatives and any existing ones should be phased out and no new or alternative identities developed.
NHS Reform	Continue to work closely with Scottish Government communications and marketing colleagues to share relevant information and updates on plans to reform services across NHS Scotland, including new sub-national planning arrangements.	This includes proposals to develop two new sub national communications and engagement groups (one for East Scotland and one for Scotland West) along with a national communications and engagement group to help align messaging, ensure a consistent approach, develop shared communication materials and coordinate the timing of any announcements and updates.
Training and Development	Participate in number of national communications groups and initiatives designed to share learning and best practice across NHS Scotland. Continue to undertake training and professional development to ensure the Department continues to meet the needs of the organisation.	This includes groups on accessible communications, AI best practice for communications, social media policies and the Public Health Scotland Communicators Forum. The Department has also recently joined the Chartered Institute of Public Relations (CIPR) which provides a wide range of communications training, industry respected qualifications, continuing professional development as well as research, best practice and skills guidance.

Conclusion

The communication plans outlined above are designed to address some of the key local and national healthcare priorities during 2026/27 and will be continually reviewed and adapted to take account of any new or emerging challenges and opportunities throughout the year.

NHS Forth Valley
Forth Valley NHS Board

11. Code of Corporate Governance – Annual Review
Purpose: This report is for Decision

Executive Sponsor: Kerry Mackenzie, Acting Director of Strategic Planning & Performance
Author: Jack Frawley, Board Secretary

Executive Summary

This report provides the Code of Corporate Governance as an appendix for consideration. No changes are proposed to the Code at this stage recognising that there was a Board Seminar on Governance held on 21 April 2026. Further to discussions at the Seminar and input from officers regarding technical updates, for example in relation to the Standing Financial Instructions, amendments may be brought to a future meeting for decision. Changes to Committee Terms of Reference have been pulled through as agreed by the respective bodies.

Action Required

The Forth Valley NHS Board is asked to:

(1) approve the Code of Corporate Governance as appended to the report;
(2) note that proposed changes to the Code of Corporate Governance will be submitted to a future meeting if required from the April Board Seminar and consultation with officers, and
(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

The Audit & Risk Committee considered the Code of Corporate Governance at its meeting of 27 March 2026 and recommended it to Board for approval. The Committee noted that should any amendments to the Code be required either arising from the April Board Seminar or consultation with officers, these would come through the Audit & Risk Committee prior to consideration by Board.

The Audit & Risk Committee agreed one change to its Terms of Reference under a separate agenda item at its meeting of 27 March to increase the size of the Committee from 5 to 6 Members. This change is reflected in the appended Code.

The Strategic Planning, Performance & Resources Committee agreed one change to its Terms of Reference to the Information Governance section of the Committee's remit to reflect feedback from the Head of Information Governance.

The Staff Governance Committee agreed one change to the Remuneration Committee's Terms of Reference at its meeting of 20 January 2026 to add in: "2.1.6 Agree the job description or any substantive changes to job descriptions".

Risk Assessment and Mitigation

There are no direct risk implications.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty
Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial, Digital and Infrastructure Implications
There are no direct implications.

Workforce Implications
There are no direct implications.

Quality / Patient Care Implications
There are no direct implications.

Population Health & Care Strategy
There are no direct implications.

Climate Change / Sustainability Implications
There are no direct implications.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

Appendices
Appendix 1 – Code of Corporate Governance

Code of Corporate Governance

Version	Purpose/Change	Author	Date
1.0	Annual Review of Code of Corporate Governance.	Cathie Cowan, Chief Executive Kerry Mackenzie, Head of Policy & Performance Jackie McEwan, Corporate Business Manager Sinead Hamill, Board Secretary	September 2021
2.0	Addition of amendments following review by NHS Board in September.	Cathie Cowan, Chief Executive Kerry Mackenzie, Head of Policy & Performance	November 2021
3.0	Annual Review. Review of Assurance Committee Terms of Reference. Update to Fraud Policy.	Kerry Mackenzie, Head of Policy & Performance	March 2022
3.1	Update to Terms of Reference, Corporate Objectives, Code of Conduct, Risk Management Strategy.	Kerry Mackenzie, Head of Policy & Performance	September 2022
4.0	Update to Terms of Reference, Standards of Business Conduct, Fraud Standards and Policy, Standing Financial Instructions, Risk Management Strategy.	Kerry Mackenzie, Head of Policy & Performance Jillian Thomson, Deputy Director of Finance Shona Slayford, Principal Auditor & NHS Forth Valley Fraud Liaison Officer	March 2024
5.0	Annual Review of Code of Corporate Governance.	Kerry Mackenzie, Acting Director of Strategic Planning & Performance; Jillian Thomson, Deputy Director of Finance; Jack Frawley, Board Secretary	March 2025

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Introduction

1. Code of Corporate Governance

The Code of Corporate Governance includes the following sections:

Section A - How business is organised.
Section B - Members Code of Conduct.
Section C - Standards of Business Conduct for NHS Staff.
Section D - The Fraud Standards.
Section E - Scheme of Delegation
Section F - Standing Financial Instructions.
Section G - Risk Management.

The Board keeps the Code of Corporate Governance under review and will undertake a comprehensive review annually.

2. The NHS in Scotland

The National Health Service (NHS) was established in Britain in 1948. Despite a growth in private health provision and insurance, the NHS provides the vast majority of Healthcare in Scotland.

The purpose of the NHS is to secure through the resources available the greatest possible improvement in the physical and mental health of the Nation by: promoting health; preventing ill health; diagnosing and treating injury and disease, and caring for those with long term illness and disability who require the services of the NHS' (Department of Health 1996).

Health Policy was, in the main, devolved to the Scottish Parliament under the Terms of the Scotland Act 1998 (the '1998 Act'). However, there are some areas of Health Policy which remain reserved. These are:

- Abortion
- Xenotransplantation (the use of non-human organs for transplantation)
- Embryology, Surrogacy and Genetics
- Licensing of Medicines, Medicines Supplies and Poisons (although decisions on whether the NHS should fund licensed medicines are devolved)
- Welfare foods
- The Regulation of Health Professions (although Regulation of professions not regulated prior to the 1998 Act is devolved)
- Health and Safety

The NHS in Scotland carries on the principle of collective responsibility by the State for the provision of comprehensive Health Services free at the point of use for all. Services are funded from central taxation and access should be based on need.

3. NHS Boards

The National Health Service (Scotland) Act 1972 allows for the establishment of area Health Boards to assess health needs and administer the provision of relevant healthcare. There are 14 territorial NHS Boards in Scotland, one of which is Forth Valley NHS Board.

The main legislation providing the legal framework for the NHS in Scotland is the National Health Service (Scotland) Act 1978.

The Functions of Health Boards (Scotland) Order 1991 sets out the requirements of Scottish Ministers in terms of the functions that Health Boards have to provide for healthcare to their local population. This Order details the high-level functions which the Health Board is directed by the

Minister to provide. The Board is a Board of Governance, not a representative body, nor a management body.

4. Role of the Forth Valley NHS Board

Forth Valley NHS Board (the Board) is a strategic body, accountable to the Scottish Government Health and Social Care Directorate and to Scottish Ministers for the functions and performance of NHS Forth Valley. The Board consists of the Chair, Non-Executive and Executive Members, who are appointed by the Scottish Ministers.

The Board will not concern itself with day-to-day operational matters, except where they have an impact on the overall performance of the system.

The Overall Purpose of the Forth Valley NHS Board

Effective NHS Boards articulate an ambition for their organisation whilst managing the risk contained within that ambition and demonstrating leadership by undertaking 3 key roles:

- Formulating strategy for the organisation, including the development annually of a Delivery Plan.
- Ensuring commitment and accountability by holding the organisation (all staff) to account for performance and the delivery of both improvement in population health, individual experience of care whilst operating with a context of affordability and sustainability.
- Shaping a positive culture (open, just, and fair) for the Board and organisation.

In summary our purpose is:

- as a Board we aim to optimise health, optimise care and optimise value.

The Function of the Board

- Setting the direction, including clarifying priorities and defining change and transformational expectations.
- Holding the Executive Leadership Team to account by seeking assurance that the organisation is being effectively managed and change is being successfully delivered.
- Managing risks to the quality, delivery and sustainability of services.
- Engaging with key stakeholders, as and when appropriate.
- Influencing the Board's and the wider organisational culture.
- Strategy Development - to develop a Delivery Plan which addresses the health priorities and health care needs of the resident population.
- Monitoring the effective performance of the Board's activities and ensuring achievement of its aims.
- Ensuring that resources (staff, finance and premises) are used effectively and responsibly to support local priorities and strategic objectives.
- Ensuring that Governance arrangements are robust, rigorous and effective.
- Ensuring probity and propriety in the workings of the organisation.

Responsibilities of Members of Forth Valley NHS Board

- Shared responsibility for the discharge of the functions of the Board.
- Exercise independent, impartial judgement on issues of strategy, resource allocation, performance management, key appointments and accountability to Scottish Ministers and to the local community.
- Responsibility for the overall performance of NHS Forth Valley, using information on the performance of the organisation to assess and challenge the quality of services.

Board Members support the Chair and work with other Members to discharge the functions of the Board.

5. Composition of the Board

The Board consists of the following Members appointed by the Minister:

Non-Executive Members	Executive Members
• Chair • 8 Non-Executive Members (one is Whistleblowing Champion) • Chair - Area Clinical Forum • Employee Director • 3 Local Authority Elected Members - 1 each from Local Authority notably: Clackmannanshire, Falkirk, and Stirling.	• Chief Executive • Director of Finance • Director of Public Health and Strategic Planning • Medical Director • Nurse Director

6. Individuals Roles, Responsibilities and Accountabilities[1]

	Chair	**Chief executive**	**Non-executive director**	**Executive director**
Formulate Strategy	Ensures board develops vision, strategies, and clear objectives to deliver organisational purpose.	Leads strategy development process.	Brings independence, external skills, and perspectives, and challenge to strategy development.	Takes lead role in developing strategic proposals – drawing on professional and clinical expertise (where relevant).
Ensure Accountability	Holds CE to account for delivery of strategy. Ensures board committees that support accountability are properly constituted.	Leads the organisation in the delivery of strategy. Establishes effective performance management arrangements and controls. Acts as Accountable Officer.	Holds the executive to account for the delivery of strategy. Offers purposeful, constructive scrutiny and challenge. Chairs or participates as member of key committees that support accountability.	Leads implementation of strategy within functional areas.
Shape Culture	Provides visible leadership in developing a positive culture for the organisation and ensures that this is reflected and modelled	Provides visible leadership in developing a positive culture for the organisation and ensures that this is reflected in their own	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour. Provides a safe point	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour.

[1] NHSLeadership-TheHealthyNHSBoard.pdf (leadershipacademy.nhs.uk)

	in their own and in the board's behaviour and decision making. Board culture: Leads and supports a constructive dynamic within the board, enabling contributions from all directors.	and the executive's behaviour and decision making.	of access to the board for whistle-blowers.	
Context	Ensures all board members are well briefed on external context.	Ensures all board members are well briefed on external context.		
Intelligence	Ensures requirements for accurate, timely & clear information to board/ directors (and governors for FTs) are clear to executive.	Ensures provision of accurate, timely & clear information to board/ directors (and governors for FTs).	Satisfies themselves of the integrity of financial and quality intelligence.	Takes principal responsibility for providing accurate, timely and clear information to the board.
Engagement	Plays key role as an ambassador, and in building strong partnerships with: • Patients and public • Member and governors (FT) • Clinicians and Staff • Key institutional • Stakeholders • Regulators	Plays key leadership role in effective communication and building strong partnerships with: • Patients and public • Member and governors (FT) • Clinicians and Staff • Key institutional • stakeholders • Regulators	Ensures board acts in best interests of the public. Senior independent director is available to members and governors if there are unresolved concerns (FTs).	Leads on engagement with specific internal or external stakeholder groups.

7. Values

The Purpose, Role, Functions and Responsibilities of Forth Valley NHS Board and Board Members, will be delivered in a way which upholds the organisational values. NHS Forth Valley's values represent the care our patients can expect, and how this care should be delivered by our staff.

Our local values in NHS Forth Valley are:

- Be person centred
- Be respectful
- Have integrity
- Be ambitious
- Be supportive
- Be a committed team member

Our Values should be visible in everything we do and drive the improvement of our services.

NHS Forth Valley's values are closely aligned to the NHS Scotland's values, which are shared by all staff throughout Scotland:

- Care and Compassion
- Dignity and Respect
- Openness, Honesty and Responsibility
- Quality and Teamwork

Both sets of values underpin and support NHS Scotland's national quality ambitions:

- Person-centred
- Safe
- Effective

8. Conduct, Accountability, and Openness

Members of Forth Valley NHS Board (Executive and Non-Executive) are required to comply with the Members' Code of Conduct and the Standards of Business Conduct for NHS Staff.

Board Members and staff are expected to promote and support the principles in the Members' Code of Conduct and to promote by their personal conduct the values of:

- Public Service
- Leadership
- Selflessness
- Integrity
- Objectivity
- Openness
- Accountability and stewardship
- Honest
- Respect

9. Understanding our responsibilities arising from the Code of Corporate Governance

It is the duty of the Chair and the Chief Executive to ensure that Board Members and staff understand their responsibilities. Managers are responsible for ensuring their staff understand their own responsibilities. The Code of Corporate Governance will be published on the Board's website.

10. Endowment Funds

The principles of this code of Corporate Governance apply equally to Member of Forth Valley NHS Board who have distinct legal responsibilities as Trustees of the Endowment Funds.

11. Advisory and Other Committees

The principles of this Code of Corporate Governance apply equally to all NHS Forth Valley Advisory Committees and all committees and groups which report directly to a Forth Valley Board Committee.

12. Review

The Board will review the Code of Corporate Governance on an annual basis and will revise the Code to reflect any National or Local Changes which impact on the Board and its functions. The Board may, on its own or if directed by the Scottish Ministers, vary and revoke Standing Orders for the regulations of the procedures of business of the Board and of any Committee.

13. Feedback

NHS Forth Valley aims to continuously improve the services we deliver, and it is important that this Code remains relevant, we would therefore be happy to hear from you regarding new operational statements or any other matter connected with the Code.

Comments and suggestions for improvement are most welcome and should be sent to:

Corporate Business Manager
NHS Forth Valley
Carseview House
Castle Business Park
Stirling
FK9 4SW

14. Definitions

Any expressions to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts Shall have the same meaning in the interpretation and in addition:

Definition	**Meaning**
The Accountable Officer	Is the Chief Executive of NHS Forth Valley, who is responsible to the Scottish Parliament for the economical, efficient, and effective use of resources. The Chief Executive of NHS Forth Valley is also accountable to the Board for clinical, staff and financial governance, including controls assurance and risk management, and for delivery of other statutory requirements. This is a legal appointment made by the Principal Accountable Officer of the Scottish Government. (Public Finance and Accountability (Scotland) Act 2000 Memorandum to Accountable Officers for other Public Bodies).
The Act	The National Health Service (Scotland) Act 1978 as amended.
The 2001 Regulations	The Health Board's (Membership and Procedure) (Scotland) Regulations 2001.
The 1960 Act	The Public Bodies (Admission to Meetings) Act 1960 as amended.
Board Member	A person appointed as a Member of the Board by Scottish Ministers and who is not disqualified from membership.
Board Secretary	Responsible for ensuring that the Board complies with relevant legislation and governance guidance. The Board Secretary will ensure that meetings of the Board and its Committees run efficiently and effectively, and that they are properly recorded.
Budget	Money proposed by the Board for the purpose of carrying out, for a specific period, any, or all of the functions of the Board.

Chair	The person appointed by the Scottish Ministers to lead the Board and to ensure that it successfully discharges its responsibility as a whole. The Chair of a Committee is responsible for fulfilling the duties of a Chair in relation to that Committee only.
Chief Executive	The Accountable Officer of NHS Forth Valley.
Committee	A Committee established by the Board and includes "Sub-Committee".
Committee Members	People formally appointed by the Board to sit on or to Chair specific committees.
Contract	Any arrangements including an NHS Contract.
Co-opted Member	An individual, not being a Member of the Board, who is appointed to serve on a Committee of the Board.
Community Planning Partners	Statutory Service providers, third and independent sector organisations with a stake in providing services and support to people in Forth Valley.
Director of Finance	The Chief Finance Officer of the Board.
Integration Joint Board	The constitutional arrangements for the establishment of Integration Joint Boards are set out within Scottish Statutory Instrument 2014 No. 285 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.
Meeting	A meeting of the Board or any Committee.
Member	A person appointed as a Member of the Board by Scottish Ministers, and who is not disqualified from membership. This definition includes the Chair, Executive and Non-Executive Members.
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within the Code of Corporate Governance.
Officer	An employee of NHS Forth Valley.
Department of Health and Social Care	The Scottish Government and is its legal name.
SFIs	Standing Financial Instructions.
Vice Chair	The Non-Executive Member appointed by the Cabinet Secretary Health & Social Care to take on the Chair's duties if the Chair is absent for any reason.

SECTION A

How Business is Organised - Standing Orders

Standing Orders for the Proceedings and Business of Forth Valley NHS Board

1. General

1.1. These Standing Orders for regulation of the conduct and proceedings of Forth Valley NHS Board, the common name for Forth Valley Health Board, [the Board] and its Committees are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302), as amended up to and including The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 (2016 No. 3)[2].

The Blueprint for Good Governance in NHS Scotland Second Edition[3] has informed these Standing Orders. The Blueprint describes the functions of the Board as:

- Setting the direction.
- Holding the Executive Leadership Team to account.
- Managing risk.
- Engaging stakeholders.
- Influencing culture.

Further information on the role of the Board, Board members, the Chair, Vice-Chair, and the Chief Executive is available on the NHS Scotland Board Development website (https://learn.nes.nhs.scot/17367/board-development).

1.2. The Scottish Ministers shall appoint the members of the Board. The Scottish Ministers shall also attend to any issues relating to the resignation and removal, suspension, and disqualification of members in line with the above regulations. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.

1.3. Any statutory provision, regulation, or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.

1.4. Any one or more of these Standing Orders may be varied or revoked at a meeting of the Board by a majority of members present and voting, provided the notice for the meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition, or amendment. The Board will annually review its Standing Orders.

1.5. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances. The Scottish Ministers may by determination suspend a member from taking part in the business (including meetings) of the Board. Paragraph 5.4 sets out when the person presiding at a Board meeting may suspend a Board member for the remainder of a specific Board meeting. The Standards Commission for Scotland can apply sanctions if a Board member is found to have breached the Board Members' Code of Conduct, and those include suspension and disqualification. The regulations (see paragraph 1.1) also set out grounds for why a person may be disqualified from being a member of the Board.

[2] http://www.legislation.gov.uk/ssi/2001/302/pdfs/ssi_20010302_en.pdf

[3] The Blueprint for Good Governance in NHS Scotland - Second Edition (www.gov.scot)

Board Members – Ethical Conduct

1.6 Members have a personal responsibility to comply with the Code of Conduct for Members of the Forth Valley NHS Board. The Commissioner for Ethical Standards can investigate complaints about members who are alleged to have breached their Code of Conduct. The Board will have appointed a Standards Officer. This individual is responsible for carrying out the duties of that role, however they may delegate the carrying out of associated tasks to other members of staff. The Board's appointed Standards Officer shall ensure that the Board's Register of Interests is maintained. When a member needs to update or amend their entry in the Register, they must notify the Board's appointed Standards Officer of the need to change the entry within one month after the date the matter required to be registered.

1.7 The Board's appointed Standards Officer shall ensure the Register is available for public inspection at the principal offices of the Board at all reasonable times and will be included on the Board's website.

1.8 Members must always consider the relevance of any interests they may have to any business presented to the Board or one of its committees. Members must observe paragraphs 5.6 - 5.10 of these Standing Orders and have regard to Section 5 of the Code of Conduct (Declaration of Interests).

1.9 In case of doubt as to whether any interest or matter should be declared, in the interests of transparency, members are advised to make a declaration.

1.10 Members shall make a declaration of any gifts or hospitality received in their capacity as a Board member. Such declarations shall be made to the Board's appointed Standards Officer who shall make them available for public inspection at all reasonable times at the principal offices of the Board and on the Board's website. The Register of Interests includes a section on gifts and hospitality. The Register may include the information on any such declarations or cross-refer to where the information is published.

1.11 The Board's Corporate Business Manager shall provide a copy of these Standing Orders to all members of the Board on appointment. A copy shall also be held on the Board's website.

2. Chair

2.1 The Scottish Ministers shall appoint the Chair of the Board.

3. Vice Chair

3.1 The Chair shall nominate a candidate or candidates for Vice Chair to the Cabinet Secretary. The candidate(s) must be a non-executive member of the Board. A member who is an employee of a Board is disqualified from being Vice Chair. The Cabinet Secretary will in turn determine who to appoint based on evidence of effective performance and evidence that the member has the skills, knowledge and experience needed for the position. Following the decision, the Board shall appoint the member as Vice Chair. Any person so appointed shall, so long as he or she remains a member of the Board, continue in office for such a period as the Board may decide.

3.2 The Vice Chair may at any time resign from that office by giving notice in writing to the Chair. The process to appoint a replacement Vice Chair is the process described at paragraph 3.1.

3.3 Where the Chair has died, ceased to hold office, or is unable for a sustained period of time to perform their duties due to illness, absence from Scotland or for any other reason, then the Board Secretary should refer this to the Scottish Government. The Cabinet Secretary will confirm which member may assume the role of interim chair in the period until the appointment of a new chair, or the return of the appointed chair. Where the Chair is absent for a short period due to leave (for whatever reason) the Vice Chair shall assume the role of the Chair in the conduct of the business of the Board. In either of these circumstances references to the Chair shall, so long as there is no Chair able to perform the

duties, be taken to include references to either the interim chair or the Vice Chair. If the Vice Chair has been appointed as the Interim Chair, then the process described at paragraph 3.1 will apply to replace the Vice-Chair.

4 Calling and Notice of Board Meetings

4.1 The Chair may call a meeting of the Board at any time and shall call a meeting when required to do so by the Board. The Board shall meet at least 6 times in the year and will annually approve a forward schedule of meeting dates.

4.2 The Chair will determine the final agenda for all Board meetings. The agenda may include an item for any other business; however, this can only be for business which the Board is being informed of for awareness, rather than being asked to decide. No business shall be transacted at any meeting of the Board other than that specified in the notice of the meeting except on grounds of urgency.

4.3 Any member may propose an item of business to be included in the agenda of a future Board meeting by submitting a request to the Chair. If the Chair elects to agree to the request, then the Chair may decide whether the item is to be considered at the Board meeting which immediately follows the receipt of the request, or a future Board meeting. The Chair will inform the member at which meeting the item will be discussed. If any member has a specific legal duty or responsibility to discharge which requires that member to present a report to the Board, then that report will be included in the agenda.

4.4 In the event that the Chair decides not to include the item of business on the agenda of a Board meeting, then the Chair will inform the member in writing as to the reasons why.

4.5 A Board meeting may be called if one third of the whole number of members signs a requisition for that purpose. The requisition must specify the business proposed to be transacted. The Chair is required to call a meeting within 7 days of receiving the requisition. If the Chair does not do so, or simply refuses to call a meeting, those members who presented the requisition may call a meeting by signing an instruction to approve the notice calling the meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

4.6 Before each meeting of the Board, a notice of the meeting (in the form of an agenda), specifying the time, place and business proposed to be transacted at it and approved by the Chair, or by a member authorised by the Chair to approve on that person's behalf, shall be circulated to every member so as to be available to them at least seven (7) days before the meeting. The notice shall be distributed along with any papers for the meeting that are available at that point**.**

4.7 Lack of service of the notice on any member shall not affect the validity of a meeting.

4.8 Board meetings shall be held in public. A public notice of the time and place of the meeting shall be provided at least seven (7) days before the meeting is held and shall be placed on the Board's website. The meeting papers shall be placed on the Board's website the morning of the meeting. The meeting papers will include the minutes of Board Committee and Advisory Committee meetings. The exception is that the meeting papers will not include the minutes of the Remuneration Committee. The Board may determine its own approach for committees to inform it of business which has been discussed in committee meetings for which the final minutes are not yet available. For items of business which the Board will consider in private session (see paragraph 5.22), only the Board members will normally receive the meeting papers for those items, unless the person presiding agrees that others may receive them.

4.9 Any individual or group or organisation which wishes to make a deputation to the Board must make an application to the Chair's Office at least 21 working days before the date of the meeting at which the deputation wish to be received. The application will state the subject and the proposed action to be taken.

Any member may put any relevant question to the deputation, but will not express any opinion on the subject matter until the deputation has withdrawn. If the subject matter relates to an item of business on the agenda, no debate or discussion will take place until the item is considered in the order of business.

Any individual or group or organisation which wishes to submit a petition to the Board will deliver the petition to the Chair's Office at least 21 working days before the meeting at which the subject matter may be considered. The Chair will decide whether or not the petition will be discussed at the meeting.

5 Conduct of Meetings

Authority of the Person Presiding at a Board Meeting

5.1 The Chair shall preside at every meeting of the Board. The Vice Chair shall preside if the Chair is absent. If both the Chair and Vice Chair are absent, the members present at the meeting shall choose a Board member who is not an employee of a Board to preside.

5.2 The duty of the person presiding at a meeting of the Board or one of its committees is to ensure that the Standing Orders or the committee's terms of reference are observed, to preserve order, to ensure fairness between members, and to determine all questions of order and competence. The ruling of the person presiding shall be final and shall not be open to question or discussion.

5.3 The person presiding may direct that the meeting can be conducted in any way that allows members to participate, regardless of where they are physically located, e.g. video conferencing, teleconferencing. For the avoidance of doubt, those members using such facilities will be regarded as present at the meeting.

5.4 In the event that any member who disregards the authority of the person presiding, obstructs the meeting, or conducts themselves inappropriately the person presiding may suspend the member for the remainder of the meeting. If a person so suspended refuses to leave when required by the person presiding to do so, the person presiding will adjourn the meeting in line with paragraph 5.12. For paragraphs 5.5 to 5.20, reference to 'Chair' means the person who is presiding the meeting, as determined by paragraph 5.1.

Quorum

5.5 The Board will be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least two members who are not employees of a Board. The quorum for committees will be set out in their terms of reference, however it can never be less than two Board members.

5.6 In determining whether or not a quorum is present the Chair must consider the effect of any declared interests.

5.7 If a member, or an associate of the member, has any pecuniary or other interest, direct or indirect, in any contract, proposed contract or other matter under consideration by the Board or a committee, the member should declare that interest at the start of the meeting. This applies whether or not that interest is already recorded in the Board Members' Register of Interests. Following such a declaration, the member shall be excluded from the Board or committee meeting when the item is under

consideration and should not be counted as participating in that meeting for quorum or voting purposes.

5.8 Paragraph 5.7 will not apply where a member, or an associate of theirs, interest in any company, body or person is so remote or insignificant that it cannot reasonably be regarded as likely to affect any influence in the consideration or discussion of any question with respect to that contract or matter. In March 2015, the Standards Commission granted a dispensation to NHS Board members who are also voting members of Integration Joint Boards. The effect is that those members do not need to declare as an interest that they are a member of an Integration Joint Board when taking part in discussions of general health & social care issues. However, members still have to declare other interests as required by Section 5 of the Board Members' Code of Conduct.

5.9 If a question arises at a Board meeting as to the right of a member to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting be referred to the Chair. The Chair's ruling in relation to any member other than the Chair is to be final and conclusive. If a question arises with regard to the participation of the Chair in the meeting (or part of the meeting) for voting or quorum purposes, the question is to be decided by the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.

5.10 Paragraphs 5.6-5.9 shall equally apply to members of any Board committee, whether or not they are also members of the Board, e.g, stakeholder representative.

5.11 When a quorum is not present, the only actions that can be taken are to either adjourn to another time or abandon the meeting altogether and call another one. The quorum should be monitored throughout the conduct of the meeting in the event that a member leaves during a meeting, with no intention of returning. The Chair may set a time limit to permit the quorum to be achieved before electing to adjourn, abandon or bring a meeting that has started to a close.

Adjournment

5.12 If it is necessary or expedient to do so for any reason (including disorderly conduct or other misbehaviour at a meeting), a meeting may be adjourned to another day, time, and place. A meeting of the Board, or of a committee of the Board, may be adjourned by the Chair until such day, time and place as the Chair may specify.

Business of the Meeting

The Agenda

5.13 If a member wishes to add an item of business which is not in the notice of the meeting, they must make a request to the Chair ideally in advance of the day of the meeting and certainly before the start of the meeting. The Chair will determine whether the matter is urgent and accordingly whether it may be discussed at the meeting.

5.14 The Chair may change the running order of items for discussion on the agenda at the meeting. Please also refer to paragraph 4.2.

Decision-Making

5.15 The Chair may invite the lead for any item to introduce the item before inviting contributions from members. Members should indicate to the Chair if they wish to contribute, and the Chair will invite all who do so to contribute in turn. Members are expected to question and challenge proposals constructively and carefully to reach and articulate a considered view on the suitability of proposals.

5.16 The Chair will consider the discussion, and whether or not a consensus has been reached. Where the Chair concludes that consensus has been reached, then the Chair will normally end the discussion of an item by inviting agreement to the outcomes from the discussion and the resulting decisions of the Board.

5.17 As part of the process of stating the resulting decisions of the Board, the Chair may propose an adaptation of what may have been recommended to the Board in the accompanying report, to reflect the outcome of the discussion.

5.18 The Board may reach consensus on an item of business without taking a formal vote, and this will normally be what happens where consensus has been reached.

5.19 Where the Chair concludes that there is not a consensus on the Board's position on the item and/ or what it wishes to do, then the Chair will put the decision to a vote. If at least two Board members ask for a decision to be put to a vote, then the Chair will do so. Before putting any decision to vote, the Chair will summarise the outcome of the discussion and the proposal(s) for the members to vote on.

5.20 Where a vote is taken, the decision shall be determined by a majority of votes of the members present and voting on the question. In the case of an equality of votes, the Chair shall have a second or casting vote. The Chair may determine the method for taking the vote, which may be by a show of hands, or by ballot, or any other method the Chair determines.

5.21 While the meeting is in public the Board may not exclude members of the public and the press (for the purpose of reporting the proceedings) from attending the meeting.

Board Meeting in Private Session

5.22 The Board may agree to meet in private in order to consider certain items of business. Items will be detailed on the Board meeting agenda noting the grounds for consideration in closed session. The Board may decide to meet in private on the following grounds:

- The Board is still in the process of developing proposals or its position on certain matters and needs time for private deliberation.
- The business relates to the commercial interests of any person and confidentiality is required, e.g., when there is an ongoing tendering process or contract negotiation.
- The business necessarily involves reference to personal information and requires to be discussed in private in order to uphold the Data Protection Principles.
- The Board is otherwise legally obliged to respect the confidentiality of the information being discussed.

5.23 The minutes of the meeting will reflect when the Board has resolved to meet in private.

Minutes

5.24 The names of members present at a meeting of the Board, or of a committee of the Board, shall be recorded in the minute of the meeting. The names of other persons in attendance shall also be recorded.

5.25 The Board Secretary (or their authorised nominee) shall prepare the minutes of meetings of the Board and its committees. The Board or the committee shall review the draft minutes at the following meeting. The person presiding at that meeting shall sign the approved minute.

6 Matters Reserved to the Board

Introduction

6.1 The Scottish Government retains the authority to approve certain items of business. There are other items of the business which can only be approved at an NHS Board meeting, due to either Scottish Government directions or a Board decision in the interests of good governance practice.

6.2 This section summarises the matters reserved to the Board and should be read in conjunction with Section 3 of the Scheme of Delegation:

a) Approval of the Code of Corporate Governance, which encompasses: Standing Orders, Committee arrangements and Terms of Reference, Scheme of Delegation, Fraud Standards and Policy, and Standing Financial Instructions.
b) The establishment and terms of reference of all its committees, and appointment of committee members.
c) Organisational Values.
d) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
e) The Delivery Plan for submission to the Scottish Government for its approval.
(Note: The Board should consider the draft for submission in private session. Once the Scottish Government has approved the Delivery Plan, the Board should receive it at a public Board meeting).
f) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
g) Risk Management Policy.
h) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
i) Annual accounts and report.
(Note: This must be considered when the Board meets in private session. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts, or any information drawn from it before the accounts are laid before the Scottish Parliament. Similarly, the Board cannot publish the report of the external auditors of their annual accounts in this period).
j) Any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval. The Board shall comply with the Scottish Capital Investment Manual.
k) The Board shall approve the content, format, and frequency of performance reporting to the Board.
l) The appointment of the Board's chief internal auditor.
(Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The audit committee should advise the Board on the appointment, and the Board may delegate to the audit committee oversight of the process which leads to a recommendation for appointment).

6.3 The Board may be required by law or Scottish Government direction to approve certain items of business, e.g, the integration schemes for a local authority area.

6.4 The Board itself may resolve that other items of business are deemed to be reserved for the Board.

7 Delegation of Authority by the Board

7.1 Except for the Matters Reserved for the Board, the Board may delegate authority to act on its behalf to committees, individual Board members, or other Board employees. In practice this is achieved primarily through the Board's approval of the Standing Financial Instructions and the Scheme of Delegation available on the NHS Board website.

7.2 The Board may delegate responsibility for certain matters to the Chair for action. In such circumstances, the Chair should inform the Board of any decision or action subsequently taken on these matters.

7.3 The Board and its officers must comply with the NHS Scotland Property Transactions Handbook, and this is cross-referenced in the Scheme of Delegation.

7.4 The Board may, from time to time, request reports on any matter or may decide to reserve any decision for itself. The Board may withdraw any previous act of delegation to allow this.

8 Execution of Documents

8.1 Where a document requires to be authenticated under legislation or rule of law relating to the authentication of documents under the Law of Scotland, or where a document is otherwise required to be authenticated on behalf of the Board, it shall be signed by an executive member of the Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the Requirements of Writing (Scotland) Act 1995. Before authenticating any document, the person authenticating the document shall satisfy themselves that all necessary approvals in terms of the Board's procedures have been satisfied. A document executed by the Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.

8.2 Scottish Ministers shall direct which officers of the Board can sign on their behalf in relation to the acquisition, management, and disposal of land.

8.3 Any authorisation to sign documents granted to an officer of the Board shall terminate upon that person ceasing (for whatever reason) from being an employee of the Board, without further intimation or action by the Board.

9 Committees

9.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. NHS Scotland Board Development website will identify the committees which the Board must establish.
https://learn.nes.nhs.scot/17367/boarddevelopment)

9.2 The Board shall appoint the chairs of all committees. The Board shall approve the terms of reference and membership of the committees. The Board shall review these as and when required and shall review the terms within 2 years of their approval if there has not been a review.

9.3 The Board shall appoint committee members to fill any vacancy in the membership as and when required. If a committee is required by regulation to be constituted with a particular membership, then the regulation must be followed.

9.4 Provided there is no Scottish Government instruction to the contrary, any non-executive Board member may replace a committee member who is also a non-executive Board member, if such a replacement is necessary to achieve the quorum of the committee.

9.5 The Board's Standing Orders relating to the calling and notice of Board meetings, conduct of meetings, and conduct of Board members shall also be applied to committee meetings where the committee's membership consist of or include all the Board members. Where the committee's members include some of the Board's members, the committee's meetings shall not be held in public and the associated committee papers shall not be placed on the Board's website, unless the Board specifically elects otherwise. Generally, Board members who are not members of a committee may attend a committee meeting and have access to the meeting papers. However, if the committee elects

to consider certain items as restricted business, then the meeting papers for those items will normally only be provided to members of that committee. The chair of the committee meeting may agree to share the meeting papers for restricted business papers with others.

9.6 The Board shall approve a calendar of meeting dates for its committees. The committee chair may call a meeting any time and shall call a meeting when requested to do so by the Board.

9.7 The Board may authorise committees to co-opt members for a period up to one year, subject to the approval of both the Board and the Accountable Officer. A committee may decide this is necessary to enhance the knowledge, skills, and experience within its membership to address a particular element of the committee's business. A co-opted member is one who is not a member of Forth Valley NHS Board and is not to be counted when determining the committee's quorum.

ANNEX A: SUSPENSION AND DISQUALIFICATION

(1) Subject to paragraphs (2) and (3), a person shall be disqualified from being a Member, if:

(a) they have, within the period of five years immediately preceding the proposed date of appointment, been convicted in the United Kingdom, the Channel Islands, the Isle of Man, or the Irish Republic of any offence in respect of which they have received a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

(b) their estate has been sequestrated in Scotland or they have otherwise been adjudged bankrupt elsewhere, they have granted a trust deed for the benefit of their creditors or entered into any arrangement with their creditors, or a curator bonis or judicial factor has been appointed over their affairs.

(c) they have resigned or been removed or been dismissed, otherwise than by reason of redundancy, from any paid employment or office with a health service body.

(d) they are a person whose appointment as the chairperson, member or director of a health service body has been terminated other than by the expiration of their term of office.

(e) they are a chairperson, member, director, or employee of a health service body outwits the Forth Valley NHS Board area.

(f) they have had their name removed, by a direction under section 29 of the Act, from any list prepared under Part II of the Act and have not subsequently had their name included in such a list.

(g) they are a person whose name has been included in any list prepared under Part II of the Act, and whose name has been withdrawn from the list on their own application.

(h) they have had their name removed, by a direction under section 46 of the 1977 Act from any list prepared under Part II of the 1977 Act and have not subsequently had their name included in such a list.

(i) they are a person whose name has been included in any list prepared under Part II of the 1977 Act, and whose name has been withdrawn from the list on their own application.

(j) they are a person who is subject to a disqualification order under the Company Directors Disqualification Act 1986; or

(k) they are a person who has been removed from the position of trustee of a charity, whether by the court or by the Charity Commissioner.

(2) For the purpose of paragraph (1):

(a) the disqualification attaching to a person whose estate has been sequestrated shall cease if and when -

(i) the sequestration of their estate is recalled or reduced; or
(ii) the sequestration is discharged.

(b) the disqualification attaching to a person by reason of their having been adjudged bankrupt shall cease if and when -

(i) the bankruptcy is annulled; or
(ii) they are discharged.

(c) the disqualification attaching to a person in relation to whose estate a judicial factor has been appointed shall cease if and when -

(i) that appointment is recalled; or
(ii) the judicial factor is discharged.

(d) the disqualification attaching to a person who has granted a trust deed or entered into an arrangement with their creditors shall cease if and when that person pays their creditors in full or on the expiry of five years from the date of their granting the deed or entering into the arrangement.

(3) The Scottish Ministers may direct that in relation to any individual person or Board any disqualification so directed shall not apply in relation thereto.

(4) For the purposes of paragraph (1)(a) the date of conviction shall be deemed to be the date on which the days of appeal expire without any appeal having been lodged, or if an appeal has been made, the date on which the appeal is finally disposed of or treated as having been abandoned.

ANNEX B: ASSURANCE COMMITTEE TERMS OF REFERENCE

- Audit and Risk Committee
- Clinical Governance Committee
- Pharmacy Practices Committee
- Remuneration Committee
- Staff Governance Committee
- Strategic Planning, Performance and Resources Committee

AUDIT AND RISK COMMITTEE - TERMS OF REFERENCE

1. Purpose

1.1 The purpose of the Audit and Risk Committee is to ensure that NHS Board activities including Patients' Private Funds are:

- within the law and regulations governing the NHS.
- that an effective system of internal control is maintained to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided, and reliable financial information produced and that value for money is continuously sought.

2. Duties & Responsibilities

2.1 Objectives

The main objectives of the Audit and Risk Committee are to ensure that NHS Forth Valley acts within the law, regulations, and code of conduct applicable to it and that an effective system of internal control is maintained. The duties of the Audit and Risk Committee are in accordance with the Public Sector Internal Audit Standards and the Scottish Government Audit and Assurance Committee Handbook. The Audit and Risk Committee will also periodically review its own effectiveness and report the results of that review to the Board and Accountable Officer.

2.2 Internal Control and Corporate Governance

The Committee will, in respect of the framework of internal control and corporate governance:

- evaluate the Control environment.
- evaluate the adequacy and effectiveness of the organisation's risk management arrangements, systems, and processes.
- approve the annual risk management reports on effectiveness, adequacy, and robustness of the risk management system.
- evaluate the adequacy of the decision-making processes.
- evaluate reliability of information and communication.
- be responsible for monitoring and corrective action.
- review the effectiveness of the Anti-fraud policies, and arrangements for special investigations.
- review the system of internal finance control, including:
  - (i) the safeguarding of assets against unauthorised use and disposition.
  - (ii) maintenance of proper accounting records and the reliability of financial information used within the organisation or for publication.
- ensure the NHS Board's activities are within the law and regulations governing the NHS.
- Review, and thereafter, recommend approval to the NHS Board of the Risk Management Strategy.
- present an annual assurance statement on the above to the NHS Board to support the Governance Statement.
- take account of the implications of publications detailing best audit practice.
- take account of recommendations contained in the relevant reports of the Auditor General and the Scottish Parliament.
- Review the Standing Committee annual reports prior to presentation to Board.
- provide an Annual Report of the Committee's activities to the Forth Valley NHS Board, to inform the preparation and review of the Board's Governance Statement.

- Review the draft Governance Statement.
- scrutinise the Strategic Risks aligned to the Committee.

2.3 Internal Audit

The Committee will:

- influence, review and approve the Internal Audit Strategic and Annual Plan, and resource plan.
- Approve the Internal Audit Strategy and Charter, including the mandate.
- monitor audit progress, governance, management and reporting arrangements to obtain assurance that the internal audit service is fulfilling its mandate and review audit reports.
- monitor the management action taken in response to audit recommendations.
- consider the Chief Internal Auditor's annual report and assurance statement.
- review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency, and performance measures.
- maintain direct contact with Internal Audit and meet periodically with the Chief Internal Auditor as required without the presence of the Executive Directors.
- review the terms of reference and appointment of the Internal Auditors.
- champion and demonstrate support for Internal Audit
- collaborate with senior management to provide the internal audit function with sufficient resources to fulfil the Mandate and achieve the plan
- assist with setting audit priorities and approve the internal audit functions performance objectives, at least annually
- consider the results of the internal audit function's quality assurance and improvement programme
- review and approve arrangements for the internal audit external assessment.

2.4 External Audit

The Committee will:

- review the Audit Plan.
- consider all statutory audit material, in particular:
  (i) Audit Reports (including Performance Audit Studies)
  (ii) Annual Reports
  (iii) Management Letters relating to the certification of the NHS Board.

- monitor management action taken in response to all External Audit recommendations including Performance Audit Studies following consideration by the relevant Governance Committee.
- hold meetings with the External Auditors at least once per year without the presence of the Executive Directors.
- review the extent of co-operation between External and Internal Audit.
- Annually appraise the performance of the External Auditors.
- note the appointment and remuneration of External Auditors and to examine any reason for the resignation or dismissal of the Auditors.

2.5 Standing Orders and Standing Financial Instructions

The Committee will:

- conduct an annual review of the Code of Corporate Governance and recommend approval to the Forth Valley NHS Board.

- examine the circumstances associated with each occasion when Standing Orders are waived or suspended.

2.6 Annual Accounts

The Committee will:

- review, and approve, annually any changes in accounting policy.
- Review Service Audit reports.
- review a schedule of losses and compensation payments.
- review and recommend approval to the NHS Board of the Annual Accounts.
- report in the Directors Report on the roles and responsibilities of the Audit Committee and actions taken to discharge those.
- review and recommend approval to the NHS Board of the Patients Funds Annual Accounts.

Other Matters

- The Committee has a duty to keep up to date by having a mechanism to ensure topical legal and regulatory requirements are brought to Members' attention
- The Committee shall monitor how the Board controls risk and possible litigation
- The Committee shall agree the level of detail it wishes to receive from the Internal and External Auditors.

3. Composition

3.1 Membership of the Audit & Risk Committee shall comprise:

- six Non-Executive Members of the Forth Valley NHS Board.

3.2 The Chair of Forth Valley NHS Board and Executive Forth Valley NHS Board Members are not eligible for Membership but may attend meetings of the Committee.

3.3 The Committee Chair shall be appointed at a meeting of Forth Valley NHS Board in accordance with the Standing Orders. The Chair shall preside at every meeting of the Committee. In the event that the Chair of the Committee is unable to attend, another Non-Executive Member will be designated as Chair for the meeting.

3.4 The Director of Finance shall serve as the Lead Executive Officer to the Committee.

The Executive Lead will oversee the development of an annual workplan for the Committee which reflects its remit and the need to provide appropriate assurance at the year-end for both the Committee and the Forth Valley NHS Board.

4. Quorum

4.1 No business shall be transacted unless a minimum of three Non-Executive Board Members are present.

5. Attendees

5.1 The Chief Executive, Director of Finance, the Chief Internal Auditor and the Statutory External Auditor shall normally attend meetings. The Committee can request the attendance of any officer of NHS Forth Valley at its meetings.

5.2 All NHS Board Members shall have the right of attendance and have access to papers, except where the Committee resolves otherwise.

6. Frequency

6.1 To fulfil its remit the Audit & Risk Committee will meet no fewer than four times in a year but may elect to have additional meetings, at the discretion of the Chair. The Committee will conduct its meetings in accordance with the Standing Orders.

6.2 If necessary, meetings of the Committee shall be convened and attended exclusively by Members of the Committee and/or the External Auditor or Internal Auditor.

7. Agenda & Papers

7.1 The agenda and supporting papers will normally be sent out at least five working days in advance of the meetings.

7.2 All papers will be completed on the approved NHS Forth Valley template and clearly state the agenda reference, the author and the purpose of the paper together with the action the Committee are asked to consider.

8. Minutes

8.1 Formal Minutes will be kept of the proceedings. Draft minutes shall be distributed for consideration and review to the Chair of the Committee within 2 weeks of the meeting, except in exceptional circumstances.

8.2 The draft minutes will be circulated electronically to Committee Members for approval following sign off by the Committee Chair. These minutes will then be presented to the next meeting of the Committee for ratification.

8.3 Minutes will be included for noting in subsequent Board Meeting papers following ratification by Committee.

9. Authority

9.1 The Committee is authorised to:

- ensure compliance with due process relating to any investigation of activities which are within the terms of its responsibility and duties. In doing so the Committee is authorised to seek information it requires from any Board member or employee, paying due regard to professional responsibilities and personal data rights. All members and employees are expected to co-operate with reasonable requests made by the Committee.
- approve matters as described within its responsibility and duties.

9.2 The Committee may establish sub-committees or sub-groups to support its functions.

9.3 The Committee may co-opt additional members for a period not exceeding a year to provide specialist skills, knowledge and experience.

10. Reporting Arrangements

10.1 The Committee will report to the Board through submission of its approved minutes.

10.2 The Chair of the Committee has a standing invitation to report verbally on key issues which the committee considered should be brought to the Board's attention.

10.3 The Committee will provide an Annual Report on the Committee's activities to the Forth

Valley NHS Board, to inform the preparation and review of the Board's Governance Statement. The report shall include: attendees; frequency and dates of meetings; Committee activities, including confirmation of delivery of the Annual Workplan and review of the Committee Terms of Reference; improvements overseen; matters of concern and emerging issues.

11. Review of Terms of Reference

11.1 The Terms of Reference will be reviewed annually by the Committee and recommended to the Board for approval.

12. Conduct of Business

12.1 Business will be conducted in accordance with the Board's Standing Orders.

CLINICAL GOVERNANCE COMMITTEE - TERMS OF REFERENCE

1. Purpose

1.1 The purpose of the Clinical Governance Committee is to provide the NHS Board with:

- Systems Assurance – to ensure effective Clinical Governance is in place and effective throughout the local NHS system and services and is effective in services that are commissioned from independent providers and other partner agencies.
- Public Health Governance – to ensure that the principles and standards of clinical governance are applied to the health improvement, health protection and healthcare public health activities of the NHS Board.
- Clinical Risk Management – assurance that an appropriate approach is in place to deal with clinical risk management across the system, working within the NHS Forth Valley Risk Management Strategy.

2. Duties & Responsibilities

2.1 **Objectives**

The main objectives of the Clinical Governance Committee are to provide:

- Systems Assurance
- Public Health Governance
- Clinical Risk Management.

2.2 **Responsibilities**

The Committee will: -

- ensure that all elements of the Clinical Governance Framework, including learning, within the Quality Strategy are implemented effectively and efficiently across the system.
- ensure that appropriate standards of clinical governance are being applied to the health improvement, health protection, healthcare public health and screening programme activities of the Board.
- ensure that appropriate delivery of NHS Forth Valleys Clinical Governance Strategic Implementation Plan (CGSIP) is reported upon.
- ensure that follow-up action is taken in relation to external reviews to provide assurance that the quality of services is being improved.
- promote positive complaints handling, advocacy and feedback including learning from adverse events, near misses and whistleblowing cases.
- ensure review of clinical governance objectives bi-annually to gain assurance across the whole NHS system with appropriate monitoring and action planning.
- ensure systems dealing with revalidation/fitness to practice are in place.
- review performance in management of clinical and population-based risk and delivery of services, including emergency planning and service continuity planning.
- receive regular reports that allow the Committee to assure the Board on key clinical priorities within a clear forward plan.
- oversee medical education governance through receiving an annual report from the Director of Medical Education.
- receive reports from the, NHS Forth Valley Area Prevention & Control of Infection Committee, and Child Protection Action Group Quarterly Report.
- receive minutes of the Clinical Governance Working Group. Recognising the issues of relative timing and scheduling of meetings, minutes of the Clinical

Governance Working Group may be presented in draft form to the next meeting of the Clinical Governance Committee.

- receive minutes of the Organ Donation Sub-Committee.
- provide an Annual Report on the Committee's activities to the Forth Valley NHS Board, to inform the preparation and review of the Board's Governance Statement.

3. Composition

3.1 The Membership of the Committee shall comprise:

- Five Non-Executive Members of the NHS Board, including
- Chair of Area Clinical Forum
- Chair of the Board, ex-officio

3.2 The Chairperson of the Committee shall be appointed at a meeting of Forth Valley NHS Board in accordance with Standing Orders. The Committee Chair shall preside at every meeting of the Committee. In the event that the Chair of the Committee is unable to attend, another Non-Executive Member will be designated as Chair for the meeting.

3.3 The Medical Director and Executive Nurse Director shall jointly serve as the Lead Executives of the Committee.

The Executive Leads will oversee the development of an annual workplan for the Committee which reflects its remit and the need to provide appropriate assurance at the year-end for both the Committee and the Forth Valley NHS Board.

4. Quorum

4.1 No business shall be transacted unless a minimum of three Non-Executive Board Members are present.

5. Attendees

5.1 The Chief Executive, Director of Public Health, Director of Pharmacy, Head of Clinical Governance and the Infection Control Manager shall normally attend. The Committee can request the attendance of any officer or family practitioner of NHS Forth Valley at its meetings.

5.2 All NHS Board Members shall have the right of attendance and have access to papers except where the Committee resolves otherwise.

6. Frequency

6.1 To fulfil its remit the Clinical Governance Committee will meet no fewer than six times in a year but may elect to have additional meetings, at the discretion of the Chair. The Committee will conduct its meetings in accordance with the Standing Orders.

7. Agenda & Papers

7.1 The agenda and supporting papers will normally be sent out at least five working days in advance of the meetings.

7.2 All papers will be completed on the approved NHS Forth Valley template and clearly

state the agenda reference, the author and the purpose of the paper together with the action the Committee are asked to consider.

8. Minutes

8.1 Formal Minutes will be kept of the proceedings. Draft minutes shall be distributed for consideration and review to the Chair of the Committee within 2 weeks of the meeting, except in exceptional circumstances.

8.2 The draft minutes will be circulated electronically to Committee Members for approval following sign off by the Committee Chair. These minutes will then be presented to the next meeting of the Committee for ratification.

8.3 Minutes will be included for noting in subsequent Board Meeting papers following ratification by Committee.

9. Authority

9.1 The Committee is authorised to:

- ensure compliance with due process relating to any investigation of activities which are within the terms of its responsibility and duties. In doing so the Committee is authorised to seek information it requires from any Board member or employee, paying due regard to professional responsibilities and personal data rights. All members and employees are expected to co-operate with reasonable requests made by the Committee.
- obtain professional advice it considers necessary.
- approve matters as described within its responsibility and duties.

9.2 The Committee may establish sub-committees or sub-groups to support its functions, which shall include the Organ Donation Sub-Committee.

10. Reporting Arrangements

10.1 The Committee will report to the Board through submission of its approved minutes.

10.2 The Chair of the Committee has a standing invitation to report verbally on key issues which the committee considered should be brought to the Board's attention.

10.3 The Committee will provide an Annual Report on the Committee's activities to the Forth Valley NHS Board, to inform the preparation and review of the Board's Governance Statement. The report shall include: attendees; frequency and dates of meetings; Committee activities, including confirmation of delivery of the Annual Workplan and review of the Committee Terms of Reference; improvements overseen; matters of concern and emerging issues.

11. Review of Terms of Reference

11.1 The Terms of Reference will be reviewed annually by the Committee and recommended to the Board for approval.

12. Conduct of Business

12.1 Business will be conducted in accordance with the Board's Standing Orders.

PHARMACY PRACTICES COMMITTEE
TERMS OF REFERENCE

1. PURPOSE

1.1 The Committee shall be known as the Pharmacy Practices Committee and shall consider, determine and approve/reject applications for inclusion in the Pharmaceutical List in accordance with the NHS (Pharmaceutical Services) (Scotland)Regulations 2009 and the NHS (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 (SSI 2011 No. 32) and 2014 (SSI 2014 No. 148).

1.2 The Committee shall, within 10 working days of taking its decision, give written notification of it to the Board with reasons for that decision.

2. COMPOSITION

2.1 **Membership**

The Pharmacy Practices Committee is appointed by the Board and shall consist of seven (unless the Application is for premises in a neighbourhood or an adjacent neighbourhood to a controlled locality, in which case an additional member will be appointed by the Board from persons nominated by the Area Medical Committees).

Members of whom:

2.1.1 One (Chair) shall be a Non-Executive Member of the Board appointed as Chair of the Pharmacy Practices Committee and shall not be nor have previously been, a Doctor, Dentist, Ophthalmic Optician or Pharmacist or an employee of a Doctor, Dentist, Ophthalmic Optician or Pharmacist.

2.1.2 Three shall be Pharmacists of whom:

2.1.2.1 One shall be a Pharmacist whose name is not included in a Pharmaceutical List and who is not an employee of a person whose name is so listed and who shall be appointed from a list of persons nominated by the Area Pharmaceutical Committee.

2.1.2.2 Two shall be Pharmacists whose names are either included on a Pharmaceutical List or are employees of a person whose name is on such a list and shall be appointed from a list of persons nominated by the Area Pharmaceutical Committee.

2.1.3 Three shall be Lay Persons appointed by NHS Forth Valley, other than from members of the Board, and shall not be nor have previously been a Doctor, Dentist, Ophthalmic Optician or Pharmacist or an employee of person who is a Doctor, Dentist, Ophthalmic Optician or Pharmacist.

2.1.4 In circumstances where the premises that are the subject of the Application are located in the same neighbourhood as a controlled locality the Pharmacy Practices Committee shall have an additional member appointed by the Board from persons nominated by the Area Medical Committee.

2.2 **Appointment of Deputies**

The Board shall also appoint deputies including, as the case may be for 2.1.4 for each Committee Member using the same criteria as set out in 2.1.

2.3 **Eligibility**

The Board shall ensure in appointing Members and Deputies to the Pharmacy Practices Committee that the eligibility criterion set out in the National Health Service (General Pharmaceutical Services)

(Scotland) Regulations 2009 the NHS (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 and 2014 (SSI 2014 No. 148) and in accordance with the provision of The Health Act 1999 are met.

If nominations are not made available before such a date as the Board may determine, the Board may appoint as a member a person who satisfies the appropriate criteria specified in 2.1 to 2.1.4.

2.4 **Review**
Membership shall be reviewed annually.

2.5 **Attendance**
The Board may appoint an independent legal assessor to attend to provide legal and technical advice during the hearing.

A person shall attend for the purpose of taking an accurate note of the Pharmacy Practices Committee meeting.

3. MEETINGS

3.1 The Pharmacy Practices Committee shall meet as necessary to fulfil its remit.

3.2 The agenda and supporting papers will be sent at least five days before the date of the meeting. In any case where oral representations are being heard, at least 7 days' notice of the date fixed for the meeting shall be given to all parties.

3.3 **Quorum**
No business will be conducted at the meeting of the Pharmacy Practices Committee unless five Members or deputies are present of whom:

3.3.1 one shall be the Chair of the Committee or deputy Chair.

3.3.2 one shall be a non-contractor Pharmacist in accordance with 2.1.2.1 or deputy.

3.3.3 one shall be a contractor Pharmacist in accordance with 2.1.2.1 or deputy.

3.3.4 two shall be Lay Persons in accordance with 2.1.3 or deputy.

3.3.5 In circumstances where the premises that are the subject of the Application are in the same neighbourhood as a controlled locality the Pharmacy Practices Committee shall have an additional member appointed by the Board from persons nominated by the Area Medical Committee.

3.4 Formal minutes will be kept of the proceedings of the Committee and approved by Members or deputies in accordance with 3.3, with the decision and the reasons for that decision reported to the Board. A copy of the Minutes of the NHS Forth Valley Pharmacy Practices Committee will be submitted to the NHS Board for noting.

3.5 Each application submitted to the Pharmacy Practices Committee under Regulation 5 (10) shall be discussed by all Members present at the meeting but shall be determined by the following Members (or their deputies) after the Non-Contractor and Contractor Pharmacists appointed by the Pharmacy Practices Committee and, if present, the member nominated by the Area Medical Committee, have withdrawn.

3.5.1 Lay Persons in accordance with 2.1.3.

3.6 The Chair or deputy Chair shall not be entitled to vote in respect of a determination of an application submitted under Regulation 5 (10) but in the case of an equality of votes under 3.5 shall have a casting vote.

3.7 In the case of all other matters considered under Regulation 5(10) except in respect of an application submitted under Regulation 5(10) all Members of the Committee present shall determine the matter.

3.8 In the case of urgent matters the Chair, or in their absence, the deputy Chair shall be empowered by the Committee to determine matters within the remit of the Committee with the exception of applications submitted under Regulation 5(10) in circumstances where it is necessary that, as a matter of urgency, a decision should be reached between scheduled meetings of the Committee.

3.9 Any decision taken under 3.8 shall be reported to the next meeting of the Committee for endorsement.

4. REMIT

4.1 The Committee shall determine and approve/reject applications for inclusion in the Pharmaceutical List as defined in terms of Regulation 5(10) and paragraph 3 of schedule 3 of the National Health Service (General Pharmaceutical Services) (Scotland) Regulations 2009, the National Health Service (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 and 2014 (SSI 2014 No. 148) and in accordance with The Health Act 1999.

4.2 The Committee shall also be empowered to exercise other functions as are delegated to it by Forth Valley NHS Board under the National Health Service (General Pharmaceutical Services) (Scotland) Regulations 2009, the National Health Service (Pharmaceutical Services) (Scotland)Amendment Regulations 2011 and 2014 (SSI 2014 No. 148) and in accordance with The Health Act 1999 to the extent that those functions are not delegated to an Officer under the Scheme of Delegation.

4.3 Any Officer with delegated authority in respect of the provisions of the General Pharmaceutical Services under Part II of the National Health Service (Scotland) Act 1978, may refer to the Committee for determination of any matter within the Officer's delegated authority either as a matter of policy or in respect of a specific issue and the Committee shall be authorised to determine such matters.

4.4 In exercising and considering all applications submitted to it, the Committee shall have regard to the provisions of the National Health Service (General Pharmaceutical Services) (Scotland) Regulations 2009, the National Health Service (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 and 2014 (SSI 2014 No. 148) and The Health Act 1999 with particular reference to:

4.4.1 consultation with interested parties, appropriate members of the public; and

4.4.2 criterion for the granting of new pharmaceutical contracts.

5. AUTHORITY

5.1 The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

5.2 The Committee has a duty to review its own performance, effectiveness including running costs and terms of reference on an annual basis.

REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. Purpose

1.1 The Remuneration Committee is a sub-committee of the Staff Governance Committee. It provides assurance to the NHS Forth Valley Board that appropriate arrangements are in place to meet the statutory requirements as laid out in the Staff Governance Standard, in respect of the application and implementation of fair and equitable pay and performance management systems as determined by Ministers and Scottish Government.

2. Duties & Responsibilities

2.1 In relation to Executive Directors and Senior Managers on Executive pay grades, to:

2.1.1 review and approve the place on the grade scale for new post holders.

2.1.2 seek assurance that remuneration, benefits and employment related terms and conditions are in line with and fair, (whether on an individual or collective basis), in relation to the national system and the arrangements for determining those matters and to seek redress if this is determined to not be the case.

2.1.3 seek assurance that individual annual SMART performance objectives in place are aligned to the organisation's corporate vision, goals, purpose and values

2.1.4 review and approve individual annual SMART performance objectives, including overseeing the review of performance against these objectives at the mid-year point and agreeing any revisions to the objectives during the course of the year.

2.1.5 consider and approve proposals on the assessment of performance at the year-end (taking into account any factors which the Committee consider to be relevant and which may not have been known by the relevant parties at the time when objectives, including their weighting were agreed or at the mid-year point) and any changes to the remuneration or the Terms and Conditions of Employment arising from this assessment of performance during the review period. The Remuneration Committee will sign off the final versions, following discussion, which will then be sent to the National Performance Management Committee (NPMC). Following the initial assessment by the NPMC, the Remuneration Committee will sign off any documents which have been returned for amendment.

2.1.6 Agree the job description or any substantive changes to job descriptions

2.2. Review and approve annually the points awarded by the Discretionary Management Group on Consultants' Discretionary Points and provide confirmation of the process followed in the allocation of points.

2.2.1 The Remuneration Committee must be satisfied that there is equity and transparency in the process which approves performance related increases in salaries for Consultants.

2.2.2 The outcomes of the Panel convened to consider discretionary points should be in the form of a paper brought to a Remuneration Committee meeting for assurance and final approval. The purpose of this is for assurance that the Panel has reached a fair and equitable decision, and to enable final approval to be given for the remuneration award. The Remuneration Committee should also consider equality monitoring of the awarding of discretionary points to ensure equity.

2.3 In general, to:

2.3.1 Comply with any Scottish Government Health Directorates directions and take into consideration any relevant guidance on remuneration, benefits or terms and conditions of employment, including the guidance contained in the Remuneration Committee Self-Assessment Pack published by the Scottish Government and Audit Scotland in 2007.

2.3.2 Provide assurance to the Board, through the Staff Governance Committee, that systems and procedures are in place to manage the issues set out in Scottish Government guidance so that overarching staff governance responsibilities can be discharged. The Staff Governance Committee will not be given the detail of confidential employment issues that are considered by the Remuneration Committee.

2.3.3 Review and approve submissions from the Chief Executive for the terms of any Settlement Agreement, including early retiral, where there are additional costs to be borne by the Board. Such agreements may also require the approval of the Scottish Government, in accordance with procedures applicable across the public sector.

2.3.4 Seek assurance on succession planning arrangements for Executives and Senior Managers, with consideration to the skills and expertise required to meet the needs of the organisation.

2.3.5 Agree processes for Executive Level Director recruitment, including representation on recruitment panels for Chief Executive and other Executive Director appointments.

3. Composition

3.1 The membership of the Committee shall comprise of five Non-Executive Directors of the Forth Valley NHS Board, including:

- the Employee Director
- the NHS Board Chair

3.2 The Chair of the Committee will be nominated at the discretion of the Board Chair. The Chair of the Staff Governance Committee and the NHS Forth Valley Board Chair should be precluded from being appointed as the Chair of the Committee to avoid any potential conflicts of interest as the Remuneration Committee reports to the Staff Governance Committee and the Board Chair has a role in the appraisal of the Chief Executive and is the grandparent reviewer for other Executive Directors.

3.3 The Membership of the Committee will be recommended by Staff Governance Committee, for final approval by the NHS Forth Valley Board, taking into account the views of the Board Chair and the respective portfolio assignments of Non-Executive Members.

3.4 The Director of People shall serve as the Lead Executive Officer to the Committee.

3.5 The Executive Lead will oversee the development of an annual workplan for the Committee which reflects its remit and the need to provide appropriate assurance at the year-end for both the Committee and the Forth Valley NHS Board.

4. Quorum

4.1 No business shall be transacted unless a minimum of three Non-Executive Board Members are present.

5. Attendees

5.1 The Chief Executive and Director of People will be in attendance throughout to provide support and advice (apart from during their own reviews). A senior member of HR will deputise for the Director of People in their absence as appropriate, to ensure specialist HR advice is always available to the Committee.

5.2 The Chief Executive and Director of People will leave the meeting when their own remuneration and terms and conditions are to be discussed and at other times, at the discretion of the Chair.

6. Frequency

6.1 The Committee will be scheduled to meet as a minimum four times per annum, and at the Chair's discretion, conduct business by correspondence on occasions where this provides a more timely or effective mechanism.

6.2 Remuneration issues may arise between meetings and will be brought to the attention of the Committee Chair by the Chief Executive or the Director of People. The Chair may call a special meeting of the Remuneration Committee to address the issue.

7 Agenda & Papers

7.1 Due to the confidential nature of the Remuneration Committee business, and the identifiable confidential personal data included in Committee papers, in line with General Data Protection Regulations and the Data Protection Act 2018, meeting papers will only be accessible to Committee members and the agreed regular attendees.

7.2 The agenda and supporting papers will be sent out at least five working days in advance of the meetings.

7.3 All papers will clearly state the agenda reference, the author, the purpose of the paper and the key issues that the Committee is asked to consider using the agreed Board paper template.

8 Minutes

8.1 Formal Minutes will be kept of the proceedings. Draft minutes shall be distributed for consideration and review to the Chair of the Committee within 2 weeks of the meeting, except in exceptional circumstances. The minutes should be marked confidential.

8.2 The draft minutes will be circulated electronically to Committee Members for approval following sign off by the Committee Chair. These minutes will then be presented to the next meeting of the Committee for ratification.

9 Authority

9.1 The Committee is authorised to:

- Ensure compliance with due process relating to any investigation of activities which are within the terms of its responsibility and duties. In doing so, is authorised to seek information it requires from any Board member or employee, paying due regard to professional responsibilities and personal data rights. All members and employees are expected to co-operate with reasonable requests made by the Committee;

- Approve matters as described within its responsibility and duties;
- obtain whatever professional advice it requires and invite external experts to meetings.
- Request the attendance of any employee, contractor of the Board (as/if agreed on their engagement), or seek professional advice as may be required.

9.2 No Director or senior manager shall be involved in any decisions as to their own remuneration outcome.

10 Reporting Arrangements

10.1 A summary of the key items of business considered by the Committee will be presented to the Staff Governance Committee.

10.2 The Staff Governance Committee will not be given the detail of confidential employment issues considered by the Remuneration Committee.

10.3 The Remuneration Committee will submit their annual report through the Staff Governance Committee for review and the Staff Governance Committee will recommend approval to the Board. This will give relevant assurance to the Board and Accountable Officer relating to the Governance Statement.

10.4 The Committee will undertake ongoing assessment of its performance, highlighting any steps for further improvement to the way it conducts business.

10.5 The Audit Scotland Remuneration Committee Self-Assessment Framework will be used as the basis on which the business of the committee is reviewed.

11 Review of Terms of Reference

11.1 The Committee will review its Terms of Reference annually and submit them to the Staff Governance Committee for review and recommended approval to the Board.

12 Conduct of Business

12.1 Business will be conducted in accordance with the Board's Standing Orders.

12.2 All business of the Committee will be conducted in strict confidence.

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Author	Allan Rennie and Neena Mahal
Responsible Exec Lead	Kevin Reith
Date of Committee Approval	
Date of Board Approval	
Review Date	

STAFF GOVERNANCE COMMITTEE - TERMS OF REFERENCE

1. Purpose

1.1 The purpose of the Staff Governance Committee is to provide the NHS Board with the assurance that:

- There is a culture within NHS Forth Valley where the highest possible standard of staff management is understood to be the responsibility of everyone working in Forth Valley and is built upon partnership and collaboration.
- Staff governance mechanisms are in place and effective throughout the local NHS system.
- Performance is reviewed against the Staff Governance standard.

2. Duties & Responsibilities

2.1 The main duties of the Staff Governance Committee are to ensure that staff governance mechanisms are in place and effective throughout the local NHS System and that performance is reviewed against relevant Staff Governance standards. The Committee shall support the creation of a culture within the health system where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the system and is built upon partnership and collaboration.

2.2 Systems Assurance and Staff Governance

The Committee will:

- receive summary reports from the Area Partnership Forum in relation to Human Resource and Organisational Development Strategy and Policies. Policy development and approval is delegated to the Area Partnership Forum.
- monitor implementation plans to deliver the aims of the Health and Social Care: National Workforce Strategy.
- commission the introduction of structures and processes which ensure that delivery against the Staff Governance Standards, including the aligned Whistleblowing Standards, is being achieved.
- ensure consistency of policy and equity of treatment of employees.
- ensure that a consistent approach to the job evaluation is in place.
- monitor Workforce Plan development and its associated action plan.
- ensure that an appropriate approach is in place to deal with staff risk management (including staff and patient safety) across the system working within NHS Forth Valley Risk Management Strategy.
- ensure that systems and procedures are in place to monitor, manage and improve performance across the whole system.
- scutinise the Strategic Risks aligned to the Committee.
- provide staff governance information for the statement of internal control.
- receive a summary of the key items of business considered by the Remuneration Committee.

2.3 Internal Review

The Committee will:

- monitor and evaluate strategies and implementation plans relating to people management.
- review staff survey results and to monitor implementation of agreed action plans.
- monitor performance in NHS Forth Valley in:
  (i) staff communications
  (ii) learning and development
  (iii) partnership working (through links with Area Partnership Forum)
  (iv) safe and healthy working environment
  (v) Human Resource Policies and Procedures

- propose and support any policy amendment, funding, or resource submission to achieve the Staff Governance Standard recognising that such proposals will require to be assessed as part of the over-arching local prioritisation process.
- receive minutes from the Health and Safety Committee and monitor governance arrangements as they relate to staff.

2.4 External Review

The Committee will:

- take responsibility for the timely submission of all staff governance information required for national monitoring arrangements and ensure follow-up action is taken in respect of relevant external reviews such as Audit Reports.
- oversee the implementation of Everyone Matters, the national workforce vision and related workforce strategies.
  (i) Partnership Information Network Guidelines
  (ii) Fair for All

- review all appropriate Performance elements routinely.
- recognise the implementation of the 'Once for Scotland' Workforce Policies.

3. Composition

3.1 The membership of the Committee shall comprise:

- Four Non-Executive NHS Board Members
- Chair of the NHS Board, ex-officio
- Employee Director, ex-officio
- Four Lay members (from Trade Union and Professional Organisations)

3.2 The Committee Chair shall be appointed at a meeting of Forth Valley NHS Board in accordance with the Standing Orders. The Chair shall preside at every meeting of the Committee. In the event that the Chair of the Committee is unable to attend, another Non-Executive Member will be designated as Chair for the meeting.

3.3 The Director of People shall serve as the Lead Executive Officer to the Committee.

The Executive Lead will oversee the development of an annual workplan for the Committee which reflects its remit and the need to provide appropriate assurance at the year-end for both the Committee and the Forth Valley NHS Board.

4. Quorum

4.1 No business shall be transacted unless a minimum of three Non-Executive Board Members are present.

5. Attendees

5.1 The Chief Executive, Director of Nursing, Director of People and Chief Officers of the Falkirk and Clackmannanshire & Stirling IJBs (or a representative) shall normally attend meetings. The Committee can request the attendance of any officer of NHS Forth Valley at its meetings.

5.2 All NHS Board Members shall have the right of attendance and have access to papers except where the Committee resolves otherwise.

6. Frequency

6.1 To fulfil its remit the Staff Governance Committee will meet no fewer than six times in a year but may elect to have additional meetings, at the discretion of the Chair. The Committee will conduct its meetings in accordance with the Standing Orders.

7. Agenda & Papers

7.1 The agenda and supporting papers will normally be sent out at least five clear days in advance of the meetings.

7.2 All papers will be completed on the approved NHS Forth Valley template and clearly state the agenda reference, the author and the purpose of the paper together with the action the Committee are asked to consider.

8. Minutes

8.1 Formal Minutes will be kept of the proceedings. Draft minutes shall be distributed for consideration and review to the Chair of the Committee within 2 weeks of the meeting, except in exceptional circumstances.

8.2 The draft minutes will be circulated electronically to Committee Members for approval following sign off by the Committee Chair. These minutes will then be presented to the next meeting of the Committee for ratification.

8.3 Minutes will be included for noting in subsequent Board Meeting papers following ratification by Committee.

9. Authority

9.1 The Committee is authorised to:

- ensure compliance with due process relating to any investigation of activities which are within the terms of its responsibility and duties. In doing so the Committee is authorised to seek information it requires from any Board member or employee, paying due regard to professional responsibilities and personal data rights. All members and employees are expected to co-operate with reasonable requests made by the Committee.
- approve matters as described within its responsibility and duties.

9.2 The Committee may establish sub-committees or sub-groups to support its functions and will as a minimum establish a Remuneration Committee.

10. Reporting Arrangements

10.1 The Committee will report to the Board through submission of its approved minutes.

10.2 The Committee will provide an Annual Report on the Committee's activities to the Forth Valley NHS Board, to inform the preparation and review of the Board's Governance Statement.

11. Review of Terms of Reference

11.1 The Terms of Reference will be reviewed annually by the Committee and recommended to the Board for approval.

12. Conduct of Business

12.1 Business will be conducted in accordance with the Board's Standing Orders.

STRATEGIC PLANNING, PERFORMANCE AND RESOURCES COMMITTEE

TERMS OF REFERENCE

1. Purpose of the Committee

1.1 The Strategic Planning, Performance and Resources Committee will:

- influence, scrutinise and oversee the development of the strategic direction of the NHS Board, including the setting of the Board's vision and corporate objectives.
- scrutinise and oversee the planning and development of corporate policies and strategies for onward referral to the NHS Board for decision.
- oversee the planning and performance of areas related to Integration arrangements.
- scrutinise and oversee the implementation of service redesign and transformation change programmes taking a Values Based Health and Care approach.
- act as the oversight Committee for the development of NHS Forth Valley as a Population Health Organisation.
- act as the Performance Management Committee of the NHS Board with specific scrutiny of Financial and Operational performance.

2. Duties and Responsibilities

2.1 The Committee will provide assurance to the NHS Board on the areas below and as appropriate refer them to the Board for decision. It will operate within the principles of The Blueprint for Good Governance – Second Edition, **to ensure effective management, improved performance and ultimately good outcomes for all stakeholders**:

2.2 The Committee's remit will include:

- Finance and Efficiency: Financial and capital plans, allocation of resources, financial performance including the setting and delivery of savings plans and efficiencies, review of Initial Agreements and Business Cases, oversight of the delivery of the Digital and eHealth Plan.
- Whole system delivery of performance against targets and key priorities, except areas that are specifically in the remit of other Board committees such as detailed workforce and patient safety metrics.
- Strategy development, endorsing and referring them to the NHS Board for approval.
- Population Health: supporting NHS Forth Valley to embed a value-based health and care approach to delivery; oversight and performance monitoring of progress and outcomes against key social determinants of health; prioritisation of prevention; early

intervention; reducing inequalities; development, implementation and monitoring of Population Health & Care Strategy; support partnership working arrangements between NHS Forth Valley and the Community Planning Partnerships and other stakeholders.

- Climate Emergency and Sustainability and the delivery of key objectives in line with the agreed strategy.

- Infrastructure, Property and Asset Management and the progression of the Whole System Infrastructure Planning approach in line with Scottish Government Guidance.

- Information Governance and specifically the delivery of NHS Forth Valley's statutory obligations under information governance law, including the UK-GDPR, Data Protection Act 2018, Network Information Systems Regulations 2018, Public Records (Scotland) Act 2011, Freedom of Information (Scotland) Act 2002, and Environmental Information (Scotland) Regulations 2004.

- Risks aligned to the remit of this Committee providing scrutiny of Risk Assurance and Mitigation Plans for those risks escalated to the Strategic Risk Register.

- Horizon scanning to detect early signs of potentially important developments e.g., the impact of technology, demographic changes and climate change.

3. Composition of the Committee

3.1 Membership of the Strategic Planning, Performance and Resources Committee, will include all Non-Executive Directors.

3.2 In the event that the Chair of the Committee is unable to attend, another non-executive director will be designated as Chair for the meeting. Normally the Chair of the Committee would arrange this in advance.

3.3 Attendees will be invited at the discretion of the Committee Chair.

3.4 The Committee may co-opt additional members for a period not exceeding a year to provide specialist skills, knowledge and experience.

4. Quorum

4.1 No business shall be transacted unless a minimum of one third of the Committee members are present.

5. Attendees

5.1 All Executive Directors and Senior Leadership Team members shall normally attend meetings.

5.2 The Committee can request the attendance of any officer of NHS Forth Valley at its meetings and shall have the right to invite, as required, external experts to attend meetings.

5.3 The Director of Strategic Planning and Performance shall serve as the Lead Executive Officer to the Committee.

5.4 The Executive Lead will oversee the development of an annual workplan for the Committee which reflects its remit and the need to provide appropriate assurance at the year end for both the Committee and the NHS Board.

6. Frequency

6.1 To fulfil its remit the Strategic Planning, Performance and Resource Committee will normally meet no less than six times in a year but may elect to have additional meetings, at the discretion of the Chair. The Committee will conduct its meetings in line with the Standing Orders of the Board.

7. Agenda and Papers

7.1 The Executive Lead will set the agenda in conjunction with the Chair and Board Secretary.

7.2 The agenda and supporting papers will normally be sent out at least five working days in advance of the meetings.

7.3 All papers require to be completed on the approved covering paper template, clearly state the agenda reference, the author, the purpose of the paper and the action the Committee is asked to consider.

8. Minutes

8.1 Formal minutes shall be taken of the proceedings of the Committee. Draft Minutes shall be distributed for consideration and review to the Chair of the meeting within 2 weeks of the meeting except in exceptional circumstances.

8.2 The draft minutes will be circulated electronically to Committee Members for review and approval within the following 10 working days.

8.3 Minutes will be included for noting in subsequent Board Meeting papers following approval by the Committee.

9. Authority

9.1 The Committee is authorised to:

- ensure compliance with due process relating to any investigation of activities which are within the terms of its responsibility and duties. In doing so the Committee is authorised to seek information it requires from any Board member or employee, paying due regard to professional responsibilities and personal data rights. All members and employees are expected to co-operate with reasonable requests made by the Committee.

- approve matters as described within its duties and responsibilities.

9.2 The Committee may establish sub-committees or sub-groups to support its functions.

10. Reporting Arrangements

10.1 The Committee will report to the Board and commend decisions to the Board, by submitting its approved minutes to the Board.

10.2 The Committee Chair will provide an annual report on the Committee's activities to the NHS Board, to inform the preparation and review of the Board's Governance Statement.

10.3 The Committee will regularly review the annual workplan including identifying any slippage of timescales or tasks including agreeing any mitigation actions (if required) to ensure the full delivery of the Committee's remit.

10.4 The Committee will scrutinise the Strategic Risks aligned to the Committee on a bi-monthly basis.

11. Review of Terms of Reference

11.1 The Terms of Reference will be reviewed annually by the Committee for submission to the Board for the Board's consideration and approval.

12. Conduct of Business

12.1 Business will be conducted in accordance with the Board's Standing Orders.

ANNEX C: SCHEME OF DECISIONS RETAINED BY FORTH VALLEY NHS BOARD

The Code of Accountability requires the NHS Board to adopt a Schedule of Decisions that are reserved for the NHS Board.

The following decisions are for determination by the NHS Board:

1. Values and aims of Forth Valley NHS Board.

2. Forth Valley Corporate Plan including the Local Delivery Plan and Regional Planning issues.

3. Strategic Health Service Plans, all Business Cases where Capital Investment exceeds £1m.

4. Five Year Financial Plan and Annual Financial Plan.

5. Five Year Capital Plan and Annual Capital Plan.

6. Endorsement of jointly published plans with public sector partners.

7. Standing Orders including Decisions retained by the Board and the Scheme of Delegation.

8. Standing Financial Instructions.

9. Establishment, terms of reference, reporting arrangements and membership of all Committees acting on behalf of the NHS Board.

10. NHS Board Members' Register of Interests.

11. Approval of NHS Board Annual Report and Annual Accounts.

12. Financial and Performance Management Reporting Arrangements.

13. Arrangements for approval of policies required as a result of national guidelines with the exception of Human Resource policies (see Staff Governance Committee remit).

14. Recommendations to the Scottish Government relating to the closure or change of use of hospitals.

15. Acquisition and disposal of any land and property above £250,000.

16. Appointment of Executive Directors of Forth Valley NHS Board.

17. Appointment of Management Consultants/Advisors where contract value exceeds £100,000.

18. Approval of delegation of any function to an agency out with the National Health Service.

The Chief Executive is authorised to take such measures as may be required in emergency situations, subject to advising, where possible, the Chairperson and the Vice Chairperson of the Board and the relevant Standing Committee Chairperson. Where such powers are invoked, these shall be formally reported to the next relevant Standing Committee or NHS Board Meeting as appropriate.

ANNEX D: SCHEME OF DELEGATION

A clear set of rules for delegation, inclusive of financial limits is essential to ensure that effective management control of resources is exercised.

Decisions retained by the NHS Board are identified in Annex C.

All powers not retained by the NHS Board or delegated to a Committee or Sub-Committee shall be exercised on behalf of the NHS Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions they shall perform personally, and which functions have been delegated to other Officers.

The Chief Executive as Accountable Officer (Revised Memorandum to National Health Service Accountable Officers: May 2002) is also accountable to the Principal Accounting Officer of the NHS in Scotland and the Scottish Parliament. The role of the Director of Finance in devising, implementing, monitoring and supervising systems of financial control is exercised on behalf of the Chief Executive and the NHS Board.

The Scheme of Delegation and the Standing Financial Instructions form a major part of the system of control. These should be used in conjunction with the system of budgetary control and other established procedures.

SECTION B

Code of Conduct

SECTION 1: Introduction to the Code of Conduct

1.1 This Code has been issued by the Scottish Ministers, with the approval of the Scottish Parliament, as required by the Ethical Standards in Public Life etc. (Scotland) Act 2000 (the "Act").

1.2 The purpose of the Code is to set out the conduct expected of those who serve on the boards of public bodies in Scotland.

1.3 The Code has been developed in line with the nine key principles of public life in Scotland. The principles are listed in Section 2 and set out how the provisions of the Code should be interpreted and applied in practice.

My Responsibilities

1.4 I understand that the public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. I will always seek to meet those expectations by ensuring that I conduct myself in accordance with the Code.

1.5 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all situations and at all times where I am acting as a board member of my public body, have referred to myself as a board member or could objectively be considered to be acting as a board member.

1.6 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all my dealings with the public, employees and fellow board members, whether formal or informal.

1.7 I understand that it is my personal responsibility to be familiar with the provisions of this Code and that I must also comply with the law and my public body's rules, standing orders and regulations. I will also ensure that I am familiar with any guidance or advice notes issued by the Standards Commission for Scotland ("Standards Commission") and my public body, and endeavour to take part in any training offered on the Code.

1.8 I will not, at any time, advocate or encourage any action contrary to this Code.

1.9 I understand that no written information, whether in the Code itself or the associated Guidance or Advice Notes issued by the Standards Commission, can provide for all circumstances. If I am uncertain about how the Code applies, I will seek advice from the Standards Officer of my public body, failing whom the Chair or Chief Executive of my public body. I note that I may also choose to seek external legal advice on how to interpret the provisions of the Code.

Enforcement

1.10 Part 2 of the Act sets out the provisions for dealing with alleged breaches of the Code, including the sanctions that can be applied if the Standards Commission finds that there has been a breach of the Code. More information on how complaints are dealt with and the sanctions available can be found at Annex A.

SECTION 2: Key Principles of the Code of Conduct

2.1 The Code has been based on the following key principles of public life. I will behave in accordance with these principles and understand that they should be used for guidance and interpreting the provisions in the Code.

2.2 I note that a breach of one or more of the key principles does not in itself amount to a breach of the Code. I note that, for a breach of the Code to be found, there must also be a contravention of one or more of the provisions in sections 3 to 6 inclusive of the Code.

The key principles are:

Duty
I have a duty to uphold the law and act in accordance with the law and the public trust placed in me. I have a duty to act in the interests of the public body of which I am a member and in accordance with the core functions and duties of that body.

Selflessness
I have a duty to take decisions solely in terms of public interest. I must not act in order to gain financial or other material benefit for myself, family or friends.

Integrity
I must not place myself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence me in the performance of my duties.

Objectivity
I must make decisions solely on merit and in a way that is consistent with the functions of my public body when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

Accountability and Stewardship
I am accountable to the public for my decisions and actions. I have a duty to consider issues on their merits, taking account of the views of others and I must ensure that my public body uses its resources prudently and in accordance with the law.

Openness
I have a duty to be as open as possible about my decisions and actions, giving reasons for my decisions and restricting information only when the wider public interest clearly demands.

Honesty
I have a duty to act honestly. I must declare any private interests relating to my public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
I have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of my public body and its members in conducting public business.

Respect
I must respect all other board members and all employees of my public body and the role they play, treating them with courtesy at all times. Similarly, I must respect members of the public when performing my duties as a board member.

SECTION 3: General Conduct

Respect and Courtesy

3.1 I will treat everyone with courtesy and respect. This includes in person, in writing, at meetings, when I am online and when I am using social media.

3.2 I will not discriminate unlawfully on the basis of race, age, sex, sexual orientation, gender reassignment, disability, religion or belief, marital status or pregnancy/maternity; I will advance equality of opportunity and seek to foster good relations between different people.

3.3 I will not engage in any conduct that could amount to bullying or harassment (which includes sexual harassment). I accept that such conduct is completely unacceptable and will be considered to be a breach of this Code.

3.4 I accept that disrespect, bullying and harassment can be:

a) a one-off incident,
b) part of a cumulative course of conduct; or
c) a pattern of behaviour.

3.5 I understand that how, and in what context, I exhibit certain behaviours can be as important as what I communicate, given that disrespect, bullying and harassment can be physical, verbal and non-verbal conduct.

3.6 I accept that it is my responsibility to understand what constitutes bullying and harassment and I will utilise resources, including the Standards Commission's guidance and advice notes, my public body's policies and training material (where appropriate) to ensure that my knowledge and understanding is up to date.

3.7 Except where it is written into my role as Board member, and / or at the invitation of the Chief Executive, I will not become involved in operational management of my public body. I acknowledge and understand that operational management is the responsibility of the Chief Executive and Executive Team.

3.8 I will not undermine any individual employee or group of employees, or raise concerns about their performance, conduct or capability in public. I will raise any concerns I have on such matters in private with senior management as appropriate.

3.9 I will not take, or seek to take, unfair advantage of my position in my dealings with employees of my public body or bring any undue influence to bear on employees to take a certain action. I will not ask or direct employees to do something which I know, or should reasonably know, could compromise them or prevent them from undertaking their duties properly and appropriately.

3.10 I will respect and comply with rulings from the Chair during meetings of:

a) my public body, its committees; and
b) any outside organisations that I have been appointed or nominated to by my public body or on which I represent my public body.

3.11 I will respect the principle of collective decision-making and corporate responsibility. This means that once the Board has made a decision, I will support that decision, even if I did not agree with it or vote for it.

Remuneration, Allowances and Expenses

3.12 I will comply with the rules, and the policies of my public body, on the payment of remuneration, allowances and expenses.

Gifts and Hospitality

3.13 I understand that I may be offered gifts (including money raised via crowdfunding or sponsorship), hospitality, material benefits or services ("gift or hospitality") that may be reasonably regarded by a member of the public with knowledge of the relevant facts as placing me under an improper obligation or being capable of influencing my judgement.

3.14 I will never **ask for** or **seek** any gift or hospitality.

3.15 I will refuse any gift or hospitality, unless it is:

a) a minor item or token of modest intrinsic value offered on an infrequent basis;
b) a gift being offered to my public body;
c) hospitality which would reasonably be associated with my duties as a board member; or
d) hospitality which has been approved in advance by my public body.

3.16 I will consider whether there could be a reasonable perception that any gift or hospitality received by a person or body connected to me could or would influence my judgement.

3.17 I will not allow the promise of money or other financial advantage to induce me to act improperly in my role as a board member. I accept that the money or advantage (including any gift or hospitality) does not have to be given to me directly. The offer of monies or advantages to others, including community groups, may amount to bribery, if the intention is to induce me to improperly perform a function.

3.18 I will never accept any gift or hospitality from any individual or applicant who is awaiting a decision from, or seeking to do business with, my public body.

3.19 If I consider that declining an offer of a gift would cause offence, I will accept it and hand it over to my public body at the earliest possible opportunity and ask for it to be registered.

3.20 I will promptly advise my public body's Standards Officer if I am offered (but refuse) any gift or hospitality of any significant value and / or if I am offered any gift or hospitality from the same source on a repeated basis, so that my public body can monitor this.

3.21 I will familiarise myself with the terms of the Bribery Act 2010, which provides for offences of bribing another person and offences relating to being bribed.

Confidentiality

3.22 I will not disclose confidential information or information which should reasonably be regarded as being of a confidential or private nature, without the express consent of a person or body authorised to give such consent, or unless required to do so by law. I note that if I cannot obtain such express consent, I should assume it is not given.

3.23 I accept that confidential information can include discussions, documents, and information which is not yet public or never intended to be public, and information deemed confidential by statute.

3.24 I will only use confidential information to undertake my duties as a board member. I will not use it in any way for personal advantage or to discredit my public body (even if my personal view is that the information should be publicly available).

3.25 I note that these confidentiality requirements do not apply to protected whistleblowing disclosures made to the prescribed persons and bodies as identified in statute.

Use of Public Body Resources

3.26 I will only use my public body's resources, including employee assistance, facilities, stationery and IT equipment, for carrying out duties on behalf of the public body, in accordance with its relevant policies.

3.27 I will not use, or in any way enable others to use, my public body's resources:

a) imprudently (without thinking about the implications or consequences);
b) unlawfully;
c) for any political activities or matters relating to these; or
d) improperly.

Dealing with my Public Body and Preferential Treatment

3.28 I will not use, or attempt to use, my position or influence as a board member to:

a) improperly confer on or secure for myself, or others, an advantage;
b) avoid a disadvantage for myself, or create a disadvantage for others or
c) improperly seek preferential treatment or access for myself or others.

3.29 I will avoid any action which could lead members of the public to believe that preferential treatment or access is being sought.

3.30 I will advise employees of any connection, as defined at Section 5, I may have to a matter, when seeking information or advice or responding to a request for information or advice from them.

Appointments to Outside Organisations

3.31 If I am appointed, or nominated by my public body, as a member of another body or organisation, I will abide by the rules of conduct and will act in the best interests of that body or organisation while acting as a member of it. I will also continue to observe the rules of this Code when carrying out the duties of that body or organisation.

3.32 I accept that if I am a director or trustee (or equivalent) of a company or a charity, I will be responsible for identifying, and taking advice on, any conflicts of interest that may arise between the company or charity and my public body.

SECTION 4: Registration of Interests

4.1 The following paragraphs set out what I have to register when I am appointed and whenever my circumstances change. The register covers my current term of appointment.

4.2 I understand that regulations made by the Scottish Ministers describe the detail and timescale for registering interests; including a requirement that a board member must register their registrable interests within one month of becoming a board member, and register any changes to those interests within one month of those changes having occurred.

4.3 The interests which I am required to register are those set out in the following paragraphs. Other than as required by paragraph 4.23, I understand it is not necessary to register the interests of my spouse or cohabitee.

Category One: Remuneration

4.4 I will register any work for which I receive, or expect to receive, payment. I have a registrable interest where I receive remuneration by virtue of being:

a) employed;
b) self-employed;
c) the holder of an office;
d) a director of an undertaking;
e) a partner in a firm;
f) appointed or nominated by my public body to another body; or
g) engaged in a trade, profession or vocation or any other work.

4.5 I understand that in relation to 4.4 above, the amount of remuneration does not require to be registered. I understand that any remuneration received as a board member of this specific public body does not have to be registered.

4.6 I understand that if a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under Category Two, “Other Roles”.

4.7 I must register any allowances I receive in relation to membership of any organisation under Category One.

4.8 When registering employment as an employee, I must give the full name of the employer, the nature of its business, and the nature of the post I hold in the organisation.

4.9 When registering remuneration from the categories listed in paragraph 4.4 (b) to (g) above, I must provide the full name and give details of the nature of the business, organisation, undertaking, partnership or other body, as appropriate. I recognise that some other employments may be incompatible with my role as board member of my public body in terms of paragraph 6.8 of this Code.

4.10 Where I otherwise undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and how often it is undertaken.

4.11 When registering a directorship, it is necessary to provide the registered name and registered number of the undertaking in which the directorship is held and provide information about the nature of its business.

4.12 I understand that registration of a pension is not required as this falls outside the scope of the category.

Category Two: Other Roles

4.13 I will register any unremunerated directorships where the body in question is a subsidiary or parent company of an undertaking in which I hold a remunerated directorship.

4.14 I will register the registered name and registered number of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which I am a director and from which I receive remuneration.

Category Three: Contracts

4.15 I have a registerable interest where I (or a firm in which I am a partner, or an undertaking in which I am a director or in which I have shares of a value as described in paragraph 4.20 below) have made a contract with my public body:

a) under which goods or services are to be provided, or works are to be executed; and
b) which has not been fully discharged.

4.16 I will register a description of the contract, including its duration, but excluding the value.

Category Four: Election Expenses

4.17 If I have been elected to my public body, then I will register a description of, and statement of, any assistance towards election expenses relating to election to my public body.

Category Five: Houses, Land and Buildings

4.18 I have a registrable interest where I own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of my public body.

4.19 I accept that, when deciding whether or not I need to register any interest I have in houses, land or buildings, the test to be applied is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as being so significant that it could potentially affect my responsibilities to my public body and to the public, or could influence my actions, speeches or decision-making.

Category Six: Interest in Shares and Securities

4.20 I have a registerable interest where:

a) I own or have an interest in more than 1% of the issued share capital of the company or other body; or
b) Where, at the relevant date, the market value of any shares and securities (in any one specific company or body) that I own or have an interest in is greater than £25,000.

Category Seven: Gifts and Hospitality

4.21 I understand the requirements of paragraphs 3.13 to 3.21 regarding gifts and hospitality. As I will not accept any gifts or hospitality, other than under the limited circumstances allowed, I understand there is no longer the need to register any.

Category Eight: Non–Financial Interests

4.22 I may also have other interests and I understand it is equally important that relevant interests such as membership or holding office in other public bodies, companies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described. In this context, I understand non-financial interests are those which members of the public with knowledge of the relevant facts might reasonably think could influence my actions, speeches, votes or decision-making in my public body (this includes its Committees and memberships of other organisations to which I have been appointed or nominated by my public body).

Category Nine: Close Family Members

4.23 I will register the interests of any close family member who has transactions with my public body or is likely to have transactions or do business with it.

SECTION 5: Declaration of Interests

Stage 1: Connection

5.1 For each particular matter I am involved in as a board member, I will first consider whether I have a connection to that matter.

5.2 I understand that a connection is any link between the matter being considered and me, or a person or body I am associated with. This could be a family relationship or a social or professional contact.

5.3 A connection includes anything that I have registered as an interest.

5.4 A connection does not include being a member of a body to which I have been appointed or nominated by my public body as a representative of my public body or of which I am a member by reason of, or in implementation of, a statutory provision, unless:

a) The matter being considered by my public body is quasi-judicial or regulatory; or
b) I have a personal conflict by reason of my actions, my connections or my legal obligations.

Stage 2: Interest

5.5 I understand my connection is an interest that requires to be declared where the objective test is met – that is where a member of the public with knowledge of the relevant facts would reasonably regard my connection to a particular matter as being so significant that it would be considered as being likely to influence the discussion or decision-making.

Stage 3: Participation

5.6 I will declare my interest as early as possible in meetings. I will not remain in the meeting nor participate in any way in those parts of meetings where I have declared an interest.

5.7 I will consider whether it is appropriate for transparency reasons to state publicly where I have a connection, which I do not consider amounts to an interest.

5.8 I note that I can apply to the Standards Commission and ask it to grant a dispensation to allow me to take part in the discussion and decision-making on a matter where I would otherwise have to declare an interest and withdraw (as a result of having a connection to the matter that would fall within the objective test). I note that such an application must be made in advance of any meetings where the dispensation is sought and that I cannot take part in any discussion or decision-making on the matter in question unless, and until, the application is granted.

5.9 I note that public confidence in a public body is damaged by the perception that decisions taken by that body are substantially influenced by factors other than the public interest. I will not accept a role or appointment if doing so means I will have to declare interests frequently at meetings in respect of my role as a board member. Similarly, if any appointment or nomination to another body would give rise to objective concern because of my existing personal involvement or affiliations, I will not accept the appointment or nomination.

SECTION 6: Lobbying and Access

6.1 I understand that a wide range of people will seek access to me as a board member and will try to lobby me, including individuals, organisations and companies. I must distinguish between:

a) any role I have in dealing with enquiries from the public;
b) any community engagement where I am working with individuals and organisations to encourage their participation and involvement, and;
c) lobbying, which is where I am approached by any individual or organisation who is seeking to influence me for financial gain or advantage, particularly those who are seeking to do business with my public body (for example contracts/procurement).

6.2 In deciding whether, and if so how, to respond to such lobbying, I will always have regard to the objective test, which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard my conduct as being likely to influence my, or my public body's, decision-making role.

6.3 I will not, in relation to contact with any person or organisation that lobbies, do anything which contravenes this Code or any other relevant rule of my public body or any statutory provision.

6.4 I will not, in relation to contact with any person or organisation that lobbies, act in any way which could bring discredit upon my public body.

6.5 If I have concerns about the approach or methods used by any person or organisation in their contacts with me, I will seek the guidance of the Chair, Chief Executive or Standards Officer of my public body.

6.6 The public must be assured that no person or organisation will gain better access to, or treatment by, me as a result of employing a company or individual to lobby on a fee basis on their behalf. I will not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which I accord any other person or organisation who lobbies or approaches me. I will ensure that those lobbying on a fee basis on behalf of clients are not given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming.

6.7 Before taking any action as a result of being lobbied, I will seek to satisfy myself about the identity of the person or organisation that is lobbying and the motive for lobbying. I understand I may choose to

act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that I understand the basis on which I am being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code and the Lobbying (Scotland) Act 2016.

6.8 I will not accept any paid work:

a) which would involve me lobbying on behalf of any person or organisation or any clients of a person or organisation.

b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence my public body and its members. This does not prohibit me from being remunerated for activity which may arise because of, or relate to, membership of my public body, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

ANNEX A: BREACHES OF THE CODE

Introduction

1. The Ethical Standards in Public Life etc. (Scotland) Act 2000 ("the Act") provided for a framework to encourage and, where necessary, enforce high ethical standards in public life.

2. The Act provided for the introduction of new codes of conduct for local authority councillors and members of relevant public bodies, imposing on councils and relevant public bodies a duty to help their members comply with the relevant code.

3. The Act and the subsequent Scottish Parliamentary Commissions and Commissioners etc. Act 2010 established the Standards Commission for Scotland ("Standards Commission") and the post of Commissioner for Ethical Standards in Public Life in Scotland ("ESC").

4. The Standards Commission and ESC are separate and independent, each with distinct functions. Complaints of breaches of a public body's Code of Conduct are investigated by the ESC and adjudicated upon by the Standards Commission.

5. The first Model Code of Conduct came into force in 2002. The Code has since been reviewed and re-issued in 2014. The 2021 Code has been issued by the Scottish Ministers following consultation, and with the approval of the Scottish Parliament, as required by the Act.

Investigation of Complaints

6. The ESC is responsible for investigating complaints about members of devolved public bodies. It is not, however, mandatory to report a complaint about a potential breach of the Code to the ESC. It may be more appropriate in some circumstances for attempts to be made to resolve the matter informally at a local level.

7. On conclusion of the investigation, the ESC will send a report to the Standards Commission.

Hearings

8. On receipt of a report from the ESC, the Standards Commission can choose to:

- Do nothing;
- Direct the ESC to carry out further investigations; or
- Hold a Hearing.

9. Hearings are held (usually in public) to determine whether the member concerned has breached their public body's Code of Conduct. The Hearing Panel comprises of three members of the Standards Commission. The ESC will present evidence and/or make submissions at the Hearing about the investigation and any conclusions as to whether the member has contravened the Code. The member is entitled to attend or be represented at the Hearing and can also present evidence and make submissions. Both parties can call witnesses. Once it has heard all the evidence and submissions, the Hearing Panel will make a determination about whether or not it is satisfied, on the balance of probabilities, that there has been a contravention of the Code by the member. If the Hearing Panel decides that a member has breached their public body's Code, it is obliged to impose a sanction.

Sanctions

10. The sanctions that can be imposed following a finding of a breach of the Code are as follows:

- **Censure**: A censure is a formal record of the Standards Commission's severe and public disapproval of the member concerned.

- **Suspension**: This can be a full or partial suspension (for up to one year). A full suspension means that the member is suspended from attending all meetings of the public body. Partial suspension means that the member is suspended from attending some of the meetings of the public body. The Commission can direct that any remuneration or allowance the member receives as a result of their membership of the public body be reduced or not paid during a period of suspension.

- **Disqualification**: Disqualification means that the member is removed from membership of the body and disqualified (for a period not exceeding five years), from membership of the body. Where a member is also a member of another devolved public body (as defined in the Act), the Commission may also remove or disqualify that person in respect of that membership. Full details of the sanctions are set out in section 19 of the Act.

Interim Suspensions

11. Section 21 of the Act provides the Standards Commission with the power to impose an interim suspension on a member on receipt of an interim report from the ESC about an ongoing investigation. In making a decision about whether or not to impose an interim suspension, a Panel comprising of three Members of the Standards Commission will review the interim report and any representations received from the member and will consider whether it is satisfied:

- That the further conduct of the ESC's investigation is likely to be prejudiced if such an action is not taken (for example if there are concerns that the member may try to interfere with evidence or witnesses); or
- That it is otherwise in the public interest to take such a measure. A policy outlining how the Standards Commission makes any decision under Section 21 and the procedures it will follow in doing so, should any such a report be received from the ESC can be found here.

12. The decision to impose an interim suspension is not, and should not be seen as, a finding on the merits of any complaint or the validity of any allegations against a member of a devolved public body, nor should it be viewed as a disciplinary measure.

ANNEX B: DEFINITIONS

“Bullying” is inappropriate and unwelcome behaviour which is offensive and intimidating, and which makes an individual or group feel undermined, humiliated or insulted.

"Chair" includes Board Convener or any other individual discharging a similar function to that of a Chair or Convener under alternative decision-making structures.

“Code” is the code of conduct for members of your devolved public body, which is based on the Model Code of Conduct for members of devolved public bodies in Scotland.

"Cohabitee" includes any person who is living with you in a relationship similar to that of a partner, civil partner, or spouse.

“Confidential Information” includes:

- any information passed on to the public body by a Government department (even if it is not clearly marked as confidential) which does not allow the disclosure of that information to the public;
- information of which the law prohibits disclosure (under statute or by the order of a Court);
- any legal advice provided to the public body; or any other information which would reasonably be considered a breach of confidence should it be made public.

"Election expenses" means expenses incurred, whether before, during or after the election, on account of, or in respect of, the conduct or management of the election.

“Employee” includes individuals employed:

- directly by the public body;
- as contractors by the public body, or
- by a contractor to work on the public body’s premises.

“Gifts” a gift can include any item or service received free of charge, or which may be offered or promised at a discounted rate or on terms not available to the general public. Gifts include benefits such as relief from indebtedness, loan concessions, or provision of property, services or facilities at a cost below that generally charged to members of the public. It can also include gifts received directly or gifts received by any company in which the recipient holds a controlling interest in, or by a partnership of which the recipient is a partner.

“Harassment” is any unwelcome behaviour or conduct which makes someone feel offended, humiliated, intimidated, frightened and / or uncomfortable. Harassment can be experienced directly or indirectly and can occur as an isolated incident or as a course of persistent behaviour.

“Hospitality” includes the offer or promise of food, drink, accommodation, entertainment or the opportunity to attend any cultural or sporting event on terms not available to the general public.

“Relevant Date” Where a board member had an interest in shares at the date on which the member was appointed as a member, the relevant date is – (a) that date;

and (b) the 5 April immediately following that date and in each succeeding year, where the interest is retained on that 5th April.

“Public body” means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

“Remuneration" includes any salary, wage, share of profits, fee, other monetary benefit or benefit in kind.

“Securities” a security is a certificate or other financial instrument that has monetary value and can be traded. Securities includes equity and debt securities, such as stocks bonds and debentures.

“Undertaking” means:

a) a body corporate or partnership; or
b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

SECTION C

Standards of Business Conduct for NHS Staff

SECTION 1: INTRODUCTION

It is important that NHS Forth Valley and its employees maintain strict ethical standards in the conduct of NHS business and are protected from allegations of conflict of interest, acting improperly or breach of impartiality.

This Business Conduct standard reflects the three public service values which are:

Accountability
All work undertaken by NHS Forth Valley staff must be able to stand the test of scrutiny, public judgements on propriety and professional codes of conduct.

Probity
There should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff, and suppliers and in the use of information acquired in the course of NHS duties.

Openness
There should be sufficient transparency about NHS activities to promote confidence between NHS Forth Valley, its staff, and the public.

SECTION 2: AIM, PURPOSE, AND OUTCOMES

The purpose of this Business Conduct standard is to provide guidance to managers and employees of NHS Forth Valley regarding the acceptance of gifts and hospitality and on other matters relevant to standards of business conduct. This Code, and the related NHS Forth Valley Corporate Governance policies are based on legislation and NHS Circulars and Guidance documents:

- **The Legislative Framework** is contained in the Prevention of Corruption Acts 1906 and 1916 and the Ethical Standards in Public Life (Scotland) Act 2000.
- **NHS Circulars**
  - **MEL (1994) 80** entitled Corporate Governance in the NHS
  - **MEL (2000) 13,** entitled Fundraising, Income Generation and Sponsorship within the NHSiS**.**
- **Guidance** contained in the **Code of Accountability for Boards 1994** and **A Common Understanding; Guidance on Joint working between NHS Scotland and the Pharmaceutical Industry 2003**
- **The Bribery Act 2010**

A range of policy documents have been developed in NHS Forth Valley to address the requirements related to business conduct, as follows:
- The Code of Conduct for Board members
- The Standing Financial Instructions
- Theft, Fraud and Other Financial Irregularities
- Procurement Strategy
- The Whistleblowing Policy

SECTION 3: SCOPE

This Business Conduct standard will affect all employees of NHS Forth Valley

SECTION 4: PRINCIPAL CONTENT

4.1 Declaration of Interests

a) Staff are required to declare all cases where they or a close relative or associate of theirs has a controlling and/or significant financial interest in a private company, public organisation, other NHS employer or voluntary organisation which might leave the employee or NHS Forth Valley vulnerable.

b) NHS Forth Valley holds a Register of Interests and staff should declare any interests as defined above to the appropriate General Manager, using Appendix 1 (Register of Employee's Private Interests – Declaration Form).

c) Board members should declare any interests using Appendix 2 and this should be retained by the Board Secretary.

4.2 Acceptance of Gifts

Staff must never canvass or seek gifts or hospitality. Under no circumstances can staff accept personal gifts of cash. All donations of cash must be processed through the Board's Endowment arrangements.

It is acceptable for staff to receive small tokens of gratitude from a relative or carer in appreciation of care and treatment received. These are typically cards, chocolates, or biscuits. Where staff are offered gifts of greater value these must be politely refused. If this is difficult, they must refer the matter to their line manager.

It is acceptable for staff to receive small promotional items, e.g. post-its, pens, calendars, diaries. However,

- staff must not accept any offer of a gift or hospitality from any individual or organisation which stands to gain or benefit from a decision NHS Forth Valley may be involved in determining, or who is seeking to do business with NHS Forth Valley.

- staff must not accept any offer, by way of gift or hospitality, which could give rise to a reasonable suspicion of influence on their part to show favour, or disadvantage, to any individual, organisation or company.

- staff should consider whether there may be a reasonable perception that any gift received by their spouse or partner or by any company in which they have an interest, or by a partnership of which they are a partner, can or would influence their judgement.

  Note - the term 'gift' includes benefits such as relief from indebtedness, loan concessions, or provision of services at a cost below that charged to members of the public.

4.3 Hospitality

Modest hospitality may be acceptable provided it is normal and reasonable in the circumstances e.g. lunches in the course of a working visit. Any hospitality accepted should be similar in scale to that which the NHS as an employer would be likely to offer. **All other offers of hospitality should be declined.**

Staff should register with their line manager all such modest hospitality which they wish to accept, using the hospitality register declaration form (Appendix 3). In cases of doubt, staff should seek advice from their line manager.

It may not always be clear whether an individual is being invited to an event involving the provision of hospitality (e.g. formal dinner) in a personal/private capacity or as a consequence of the position which they hold with NHS Forth Valley.

(a) If the invitation is the result of the individual's position within NHS Forth Valley, only hospitality which is modest and normal and reasonable in the circumstances should be accepted. If the nature of the event dictates a level of hospitality which exceeds this, then the individual should ensure that their line manager is fully aware of the circumstances and approves their attendance. An example of such an event might be an awards ceremony involving a formal dinner. If the line manager grants approval to attend, the individual should declare their attendance in the register of hospitality held by their line manager. The approving manager must ensure that this will not result in any future conflict of interest.

(b) If the individual is invited to an event in a private capacity (e.g. as result of their qualification or membership of a professional body), they are at liberty to accept or decline the invitation without referring to their line manager. The following matters should however be considered before an invitation to an individual acting in a private capacity is accepted.

(c) The individual should not do or say anything at the event that could be construed as representing the views and/or policies of NHS Forth Valley.

(d) If the body issuing the invitation has (or is likely to have or is seeking to have) commercial or other financial dealings with NHS Forth Valley, then it could be difficult for an individual to demonstrate that their attendance was in a private and not an official capacity. Attendance could create a perception that the individual's independence had been compromised, especially where the scale of hospitality is lavish. Individuals should therefore exercise caution before accepting invitations from such bodies and must inform their line manager.

(e) Where suppliers of clinical products provide hospitality, it should only be accepted in association with scientific meetings, clinical educational meetings or equivalent, which must be modest, normal, and reasonable in the circumstances and in line with what the NHS would normally provide. Any such hospitality should be held in appropriate venues conducive to the main purpose of the event, e.g. the sponsorship is clearly disclosed in any papers relating to the meeting; products discussed should be described in relation to the Scottish Medicines Consortium, Formulary or equivalent clinical product catalogue and the active promotion of clinical products is restricted to those in the Board's Formulary and equivalent clinical product catalogues. Any educational meetings hosted by suppliers must be approved by the line manager.

(f) Before accepting an offer of hospitality, the individual concerned should fill in a Registering Hospitality Declaration Form (attached as appendix 3) and have it approved by their line manager. A copy of the request form will be held as part of a Hospitality Register which will be available for scrutiny by the NHS Board, Corporate Management Team, members of the public or press should they request such information. The arrangements for the administration of the process will be set out locally.

NHS Forth Valley as a public body must be able to demonstrate good value when incurring expenditure. Consideration must be given to the use of NHS Forth Valley venues for hospitality and entertainment including hospitality at conferences and other external events.

All NHS Forth Valley staff who participate in or authorise the provision of hospitality involving external organisations must be able to ensure that their conduct is capable of justification in the light of the public service values outlined.

4.4 Bribery Act 2010

NHS Forth Valley will uphold all laws relevant to countering bribery and corruption, including the Bribery Act 2010 (the Act). This commitment applies to every aspect of NHS Forth Valley's activity, including dealings with public and private sector organisations and the delivery of care to patients.

The Act recognises a number of offences including the following:

- The offering, promising, or giving of a bribe (active bribery).

- The requesting, agreeing to receive or accepting of a bribe (passive bribery).

Any employee who commits active or passive bribery will be subject to disciplinary action. In addition, the matter will be referred to relevant authorities for criminal investigation.

The Act also recognises a further offence of corporate liability for failing to prevent bribery on behalf of a commercial organisation. (For the purposes of the Act, NHS Boards are considered commercial organisations.) NHS Forth Valley has put in place a range of measures intended to prevent bribery and these are subject to formal and regular review to ensure they remain fit for purpose.

4.5 Assessment and training visits for new equipment

It is not acceptable for individuals within NHS Forth Valley to accept offers of travel or overnight accommodation except where such visits do not relate to the purchase of equipment but are to do with training or familiarisation of equipment which it has already been determined will be purchased. In these circumstances it is acceptable for the cost to be met by the manufacturer or supplier.

Whilst it will be necessary for staff advising on the purchase of equipment to inspect such equipment in operation in other parts of the country or exceptionally overseas, acceptance of an offer by the manufacturer to meet the costs of such visits may cast doubts on the integrity of subsequent purchasing decisions. NHS Forth Valley will

therefore meet the costs of any visits which are considered necessary. Any such visits will require to be authorised by the appropriate line manager.

4.6 Commercial Contracts

All staff who are in contact with suppliers and contractors - including external consultants - and particularly those who are authorised to sign purchase orders or place contracts for goods, materials or services are expected to adhere to professional standards as set out in the Ethical Code of the Institute of Purchasing and Supply.

4.7 Secondary Employment

Staff should seek permission from their line manager if they are planning to undertake paid work outwith their employment with NHS Forth Valley to ensure there is no conflict of interest with their post in NHS Forth Valley.

SECTION 5: ROLES AND RESPONSIBILITIES

5.1 All staff

(a) It is a basic principle in all parts of the public service that public servants must be scrupulously impartial and honest, that they must be seen to be so and that they must be beyond suspicion in all aspects of business conduct.

(b) This primary responsibility applies to **all NHS staff** - those who commit NHS resources directly e.g. by the ordering of goods, those who do so indirectly e.g. by the prescribing of medicines or those who advise on the commitment of resources. Therefore, all staff must comply with the following responsibilities:

- To ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.
- To ensure that the interests of patients remain paramount at all times.
- To be impartial and honest in the conduct of their official business.
- To use public funds entrusted to them to the best advantage of the service, always ensuring value for money.
- Not to abuse their official position for personal gain or to benefit their family or friends.
- Not to seek to advantage or further their private business or other interests in the course of their official duties.
- Not to accept gifts or bequests which will directly or indirectly benefit them, or put pressure on patients, or others to make donations to other people or organisations.

- Not to accept gifts or hospitality liable to raise any questions regarding their judgement or impartiality. Staff should decline all offers of gifts, hospitality, or entertainment except as defined in paragraph 4.2 above.

5.2 Line Managers

Line managers are required:

- To maintain the hospitality register for their area of responsibility.
- To maintain a register of employee's private interests.
- To advise the Corporate Business Manager of the above to ensure the central organisational register is update to date.

Appendix 1

Register of Employee's Private Interests

Declaration Form

I hereby declare the following private interests, which may be material and relevant to NHS business. This declaration is made in accordance with the terms of NHS Forth Valley's Code of Conduct.

Registerable Interest	Description of Interest
Remuneration	
Related undertaking	
Contracts	
Houses, land, and buildings	
Shares and securities	
Non-financial interests	

I understand these interests will be entered into a register held by the department manager or equivalent and which is available to the public. Any material changes to my circumstances will be notified to the department manager of equivalent, so that the information can be updated.

Signed: _____ Date: _____

Name (please print) _____ **Appendix 2**

Register of Interest in respect of:

Registered Interest	**Description of Interest**
Remuneration	
Other Roles	
Contracts	
Election Expenses	
Houses, Land and Buildings	
Shares and Securities	
Gifts and Hospitality	

Non-Financial Interests	
Close Family Members	

Register of Interests – Guidance Notes

Remuneration

(i) I will register any work for which I receive, or expect to receive, payment. I have a registrable interest where I receive remuneration by virtue of being:

a) employed;
b) self-employed;
c) the holder of an office;
d) a director of an undertaking;
e) a partner in a firm;
f) appointed or nominated by my public body to another body; or
g) engaged in a trade, profession or vocation or any other work.

(ii) I understand that in relation to (i) above, the amount of remuneration does not require to be registered. I understand that any remuneration received as a board member of this specific public body does not have to be registered.

(iii) I understand that if a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under Category Two,
'Other Roles'.

(iv) I must register any allowances I receive in relation to membership of any organisation under Category One.

(v) When registering employment as an employee, I must give the full name of the employer, the nature of its business, and the nature of the post I hold in the organisation.

(vi) When registering remuneration from the categories listed in paragraph (i) (b) to (g) above, I must provide the full name and give details of the nature of the business, organisation, undertaking, partnership or other body, as appropriate. I recognise that some other employments may be incompatible with my role as board member of my public body in terms of paragraph 6.7 of the Code.

(vii) Where I otherwise undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and how often it is undertaken.

(viii) When registering a directorship, it is necessary to provide the registered name and registered number of the undertaking in which the directorship is held and provide information about the nature of its business.

(ix) I understand that registration of a pension is not required as this falls outside the scope of the category.

Other Roles

(i) I will register any unremunerated directorships where the body in question is a subsidiary or parent company of an undertaking in which I hold a remunerated directorship.

(ii) I will register the registered name and registered number of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which I am a director and from which I receive remuneration.

Contracts

(i) I have a registerable interest where I (or a firm in which I am a partner, or an undertaking in which I am a director or in which I have shares of a value as described in **Shares and Securities** below) have made a contract with my public body:

a) under which goods or services are to be provided, or works are to be executed; and
b) b) which has not been fully discharged.

(ii) I will register a description of the contract, including its duration, but excluding the value.

Election Expenses

(i) If I have been elected to my public body, then I will register a description of, and statement of, any assistance towards election expenses relating to election to my public body.

Houses, Land and Buildings

(i) I have a registrable interest where I own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of my public body.

(ii) I accept that, when deciding whether or not I need to register any interest I have in houses, land or buildings, the test to be applied is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as being so significant that it could potentially affect my responsibilities to my public body and to the public, or could influence my actions, speeches or decision-making.

Shares and Securities

(i) I have a registerable interest where:

a) I own or have an interest in more than 1% of the issued share capital of the company or other body; or
b) Where, at the relevant date, the market value of any shares and securities (in any one specific company or body) that I own or have an interest in is greater than £25,000.

Gifts and Hospitality

(i) I understand the requirements of paragraphs 3.13 to 3.21 of the Code regarding gifts and hospitality. As I will not accept any gifts or hospitality, other than under the limited circumstances allowed, I understand there is no longer the need to register any.

Non-Financial Interests

(i) I may also have other interests and I understand it is equally important that relevant interests such as membership or holding office in other public bodies, companies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described. In this context, I understand non-financial interests are

those which members of the public with knowledge of the relevant facts might reasonably think could influence my actions, speeches, votes or decision-making in my public body (this includes its Committees and memberships of other organisations to which I have been appointed or nominated by my public body).

Close Family Members

(i) I will register the interests of any close family member who has transactions with my public body or is likely to have transactions or do business with it.

Appendix 3

Registering of Hospitality

Declaration Form

Hospitality offered to: (Name, title, department)	
Person of Organisation offering or providing the Hospitality and date	
Nature of Hospitality	
Estimated or actual value of Hospitality	
Any reasons for accepting, returning or refusing the Hospitality	
Authorised by: (Please print name and title)	

Please complete this form for any hospitality received and return to your line manager.

SECTION D

The Fraud Standards and Policy

The Fraud Standards

Fraud Policy

1 Introduction

2 Purpose of the Fraud Standards

3 Public service values

4 NHS Forth Valley Policy, Public Interest Disclosure Act 1998, the Bribery Act 2010 and the Whistleblowing arrangements

5 Roles and responsibilities

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7 Reporting theft, fraud, embezzlement, bribery and corruption

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Key Contacts

Annex 1

FRAUD POLICY

1. Introduction

1.1 One of the basic principles of public sector organisations is the proper use of public funds. It is therefore important that all those who work in the public sector are aware of the risk and the means of enforcing the rules against fraud, theft and other illegal acts involving embezzlement, bribery, corruption, dishonesty, or damage to property. This policy and response plan forms part of the Partnership Agreement between NHS Scotland Counter Fraud Services (CFS) and Health Boards and Appendix II of the Partnership Agreement (PA), Fraud, Bribery & Corruption Protocol (model policy and response plan) provides further detailed direction and help to staff dealing with circumstances suspected to be fraud.

1.2 NHS Forth Valley (the Board) has procedures in place that reduce the likelihood of fraud occurring. These include Standing Orders (SOs), Standing Financial Instructions (SFIs), operational procedures, a system of internal control and risk assessment. NHS Forth Valley engages CFS to promote a fraud awareness culture through a range of products and services. The PA outlines what must happen in the event of a fraud or other irregularity being discovered and includes reference to the Board and CFS proactively detecting and investigating fraud and assessing the risk of fraud and forms a key element of the Scottish Government's determination to counter fraud against NHS Scotland. This guidance is in line with the PA between NHS Forth Valley and the NHS Scotland Counter Fraud Services.
(See: Partnership Agreement (scot.nhs.uk)) In addition NHS Forth Valley also participates in the National Fraud Initiative (NFI) data matching exercise coordinated by Audit Scotland.

2. Purpose of the Fraud Standards

2.1 The purpose of this document is to provide guidance to employees on the action, which should be taken when fraud, theft, embezzlement, bribery or corruption is suspected. Such occurrences may involve employees of NHS Forth Valley, Suppliers/Contractors or any third party. This document sets out the Board's policy and response plan for detected or suspected fraud. It is not the purpose of this document to provide direction on the prevention of fraud. NHS Scotland's policy on countering fraud is detailed in the Health Board Partnership Agreement 2022-25. The PA forms a key element of the Scottish Government's determination to counter fraud against NHS Scotland.

2.2 The Partnership Agreement is referenced in the Fraud section of the Scottish Public Finance Manual. This can be found at:
https://www.gov.scot/publications/scottish-public-finance-manual/fraud-and-gifts/fraud/

2.3 Whilst the exact definition of theft, fraud or corruption is a statutory matter, the following working definitions are given for guidance:

- Theft is taking/removing property belonging to NHS Forth Valley, its staff or patients with the intention of permanently depriving the owner of its use, without their consent.
- Fraud or corruption broadly covers deliberate material misstatement, falsifying records, making or accepting improper payments or acting in a manner not in the best interest of the Board for the purposes of personal gain.

- Embezzlement is the felonious appropriation of property (i.e a thing or things belonging to someone) that has been entrusted to the accused with certain powers of management or control.

For simplicity this document will refer to all such offences as "*fraud*", except where the context indicates otherwise.

2.4 NHS Forth Valley already has procedures in place, which reduce the likelihood of fraud/theft occurring. These are included within the Standing Orders, Standing Financial Instructions and accounting procedures, a system of internal control and a system of risk assessment. The Board also engages in the post payment verification programme in relation to the validity and accuracy of payments made to Family Health Service contractors for Primary Care Services.

2.5 It is the responsibility of NHS Forth Valley and its management to maintain adequate and effective internal controls, which deter and facilitate detection of any fraud. The role of Internal Audit is to evaluate these systems of control. It is not the responsibility of Internal Audit to detect fraud, but rather to identify weaknesses in systems that could potentially give rise to error or fraud.

3. Public service values

3.1 High standards of corporate and personal conduct based on the recognition that patients come first, have been a requirement throughout the NHS since its inception. The Code of Conduct published by the Scottish Government Health Department (SGHSCD) in April 1994 (revised 2004) set out the following public service values:

Accountability: Everything done by those who work in the organisation must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

Probity: Absolute honesty and integrity should be exercised in dealing with NHS patients, assets, staff, suppliers and customers.

Openness: The organisation's activities should be sufficiently public and transparent to promote confidence between the organisation and its patients, staff and the public.

3.2 All those who work in the organisation should be aware of, and act in accordance with, the above values. In addition, NHS Forth Valley will expect and encourage a culture of openness between NHS bodies and the sharing of information in relation to any fraud.

4. NHS Forth Valley Policy, Public Interest Disclosure Act 1998 and Bribery Act 2010

4.1 NHS Forth Valley is committed to the NHS Scotland Counter Fraud Strategy and to the public service values outlined above. NHS Forth Valley is dedicated to maintaining an honest, open and well-intentioned atmosphere within the service and to the deterrence, detection and investigation of any fraud within the organisation.

4.2 NHS Forth Valley encourages anyone having reasonable suspicion of fraud, theft, embezzlement, bribery or corruption to report the incident. It is NHS Forth Valley policy that no staff member will suffer in any way as a result of reporting any reasonably held

suspicions. For these purposes "*reasonably held suspicions*" shall mean any suspicions other than those which are groundless and/or rose maliciously.

4.3 In addition, the Public Interest Disclosure Act 1998 protects whistleblowers from negative treatment or unfair dismissal. The disclosure must be made in good faith and workers must have reasonable grounds to believe that criminal offences such as fraud or theft have occurred or are likely to occur. The disclosure must not be made for personal gain.

4.4 NHS Forth Valley Whistleblowing Arrangements Policy aims to ensure that staff can safely raise concerns where they are witness to risk, malpractice or wrongdoing that affects others. Employees can be assured that concerns raised in good faith will be protected under current legislation. NHS Forth Valley staff can continue to raise any concerns with their line manager in the first instance and they can also seek support and advice from Human Resources (HR), staff-side representatives and occupational health in line with existing policies and procedures. Staff wishing to raise a concern under the Whistleblowing Policy should discuss this with one of the Confidential Contacts, whose details are given on the Intranet and available via e-mail. Details of the support available to staff and copies of current national and local policies (including the Bullying and Harassment Policy and Grievance Policy) can be found in the HR Connect section of the NHS Forth Valley staff intranet. Confidential Contacts are available via email on fv.confidentialcontact@nhs.scot or by telephone **01324 566415.**

4.5 Whistleblowing standards have been introduced from 1 April 2021 across NHS Scotland. The standards include the role of an Independent National Whistleblowing Officer which forms part of the Scottish Public Services Ombudsman. The phone line, 0800 008 6112 is open to anyone who wishes to raise concerns about practices in NHS Scotland. The focus of the new National Whistleblowing Policy in NHS Scotland is to:

- help staff raise concerns as early as possible, and,
- support and provide protection for staff when they raise concerns.

The Whistleblowing standards aim to support an open fair and just culture, where concerns can be raised early and dealt with promptly and professionally. The process set out by the National Whistleblowing Standards is a formal process.

4.6 Whilst we would encourage staff to raise any concerns or complaints through existing Board procedures, the National Confidential Alert Line for NHS Scotland employees has been established to provide an additional level of support for NHS employees who may wish to raise a concern about practices in NHS Scotland. This service is run by Protect on https://protect-advice.org.uk/, an independent whistleblowing charity. The Alert Line offers independent, confidential advice from legally trained expert staff on whether and how to raise a concern and can be contacted on 020 3117 2520. Further choices available to staff, patients and members of the public for reporting suspicions of fraud (either anonymously or as a named individual) are:

- the CFS Fraud Hotline, which is now powered by Crimestoppers, on 08000 15 16 28; or
- directly through the CFS Website on www.cfs.scot.nhs.uk.

4.7 The NHS Forth Valley Policy on Standards of Personal Business Conduct describes the minimum Standards of Business Conduct expected from all NHS staff. It is the responsibility of staff to ensure that they do not place themselves in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.

Under the Bribery Act 2010:

- It is a criminal offence to give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad.
- The maximum penalty for bribery was increased from seven to 10 years imprisonment with an unlimited fine.
- It is a corporate offence of failure to prevent bribery by persons working on behalf of a business, which means that NHS Forth Valley can be exposed to criminal liability, punishable by an unlimited fee if it fails to prevent bribery by not having adequate procedures in place that are robust, up to date and effective. The corporate offence is not a standalone offence and will follow from a bribery / corruption offence committed by an individual associated with NHS Forth Valley, in the course of their work. NHS Forth Valley therefore takes its legal responsibilities very seriously.

4.8 If a bribery offence is proved to have been committed by an outside body corporate with the consent or connivance of a director or senior officer of NHS Forth Valley, under the Act, the director or senior officer would be guilty of an offence (section 14 offence) as well as the body corporate which paid the bribe.

4.9 Staff must be aware that a breach of the provisions of this Act renders them liable to prosecution and may also lead to potential disciplinary action and the loss of their employment and superannuation rights within the NHS.

4.10 NHS Forth Valley does not tolerate any form of bribery, whether direct or indirect by its staff, agents or external consultants or any persons or entities acting for it or on its behalf.

4.11 The success of NHS Forth Valley anti-bribery measures depend on all employees, and those acting for NHS Forth Valley playing their part in helping to detect and eradicate bribery. Therefore, all employees and others acting for or on behalf of NHS Forth Valley are encouraged to report any suspected bribery (see sections 4.4 & 4.6 on ways of reporting).

5. Roles & responsibilities

5.1 As the Accountable Officer, the Chief Executive has the responsibility for countering fraud in its broadest terms. Accountable Officers are required to have adequate arrangements in place for the deterrence, prevention and detection of fraud. Responsibility for receiving information relating to suspected frauds has been delegated to the Fraud Liaison Officer (FLO). This individual is responsible for informing third parties such as CFS, Internal Audit and External Audit or the Police (where appropriate) when suspicions of potential fraud are brought to their attention, either directly or indirectly. The Scheme of Delegation included as Annex D within the Standing Orders of the Board state that the Authorised Deputy FLO is the Director of Finance.

5.2 The FLO shall inform and consult the Chief Executive and/or Director of Finance in cases where the loss may be above the delegated limit or where the incident may lead to adverse publicity. The FLO will advise the Director of Finance on any potential referral to CFS. The roles and responsibilities of NHS Fraud Liaison Officers are set

out within Annex B of CEL 11 (2013) Strategy to Combat Financial Crime in NHS Scotland' https://www.sehd.scot.nhs.uk/mels/CEL2013_11.pdf

5.3 Where a fraud is suspected within the service including Primary Care Services such as independent contractors providing Medical, Dental, Ophthalmic or Pharmaceutical Services, the FLO will make an initial assessment and, where appropriate, advise CFS. All staff have a duty to protect the assets of the Board, which include: information, physical property and cash. The Board will maintain an honest and open culture and wishes to encourage anyone having suspicions of fraud, embezzlement, bribery, corruption or systematic theft to report them without delay.

5.4 The roles and responsibilities of the Board's nominated Counter Fraud Champion are set out within https://www.sehd.scot.nhs.uk/mels/CEL2013_11.pdf
The contact details of the Counter Fraud Champion (CFC) are included in the Key Contacts listed in Annex 1 below. The CFC role is to help with the process of promoting a counter fraud message within the organisation and is vital in representing counter fraud issues at Board level and communicating to staff to promote an anti-fraud culture.

5.5 The Director of People, or nominated deputy, shall advise those involved in the investigation on matters of employment law and other procedural matters, such as disciplinary and complaints procedures.

5.6 Where the incident is thought to be subject to either local or national controversy and publicity then the Board and the Scottish Government Health and Social Care Directorates should be notified before the information is subjected to publicity. It should be added that under no circumstances should a member of staff speak or write to representatives of the press, TV, radio, other third parties or publicise details about a suspected fraud/theft on Social Network Sites, blogs or Twitter. Employees must ensure that no action take, could give rise to an action for slander or libel.

5.7 It is necessary to categorise the irregularity prior to determining the appropriate course of action. Two main categories exist:

- Theft, burglary and isolated opportunist offences; and
- Fraud, corruption and other financial irregularities.

5.8 The former will be dealt with directly by the Police whilst the latter may require disclosure under the SGHD NHS Circular No. HDL (2002) 23 – Financial Control: Procedure where Criminal Offences are suspected.

5.9 The National Fraud Initiative (NFI) in Scotland is a counter-fraud exercise led by Audit Scotland, assisted by the Cabinet Office. Data analytics compare information about individuals held by different public bodies, on different financial systems and databases to identify circumstances (matches) that might suggest the existence of fraud or error. The NFI allows public bodies to investigate these matches and, if fraud or error has taken place, to stop payments and attempt to recover the amounts involved auditors to assess the arrangements that the bodies have put in place to prevent and detect fraud. This Board participates in this exercise which is carried out every two years.

RESPONSE PLAN

6. Introduction

6.1 The following sections describe NHS Forth Valley's intended response to a reported suspicion of theft, fraud, embezzlement, bribery or corruption. It is intended to provide procedures, which allow for gathering and collating evidence in a manner that will facilitate an informed initial decision, while ensuring that evidence gathered will be admissible in any future criminal or civil action.
Each situation is different; therefore the guidance will need to be considered carefully in relation to the actual circumstances of each case before action is taken.

7. Reporting theft, fraud and corruption

7.1 Where an NHS colleague is suspected of theft, fraud, embezzlement, bribery or corruption then it is imperative that advice is sought from HR at the earliest opportunity. However, in the first instance any suspicion of fraud, theft, embezzlement, bribery or corruption should be reported to the relevant Head of Department. If the suspected theft, fraud, embezzlement, bribery or corruption involves the Head of Department then any suspicion should be reported in writing to a more senior officer or directly to the Fraud Liaison Officer (FLO). The contact details for the FLO are shown in the Key Contacts listed in Annex 1 below.

7.2 Once a suspicion regarding an NHS colleague has been reported then it is essential that contact should be made with HR before proceeding with any internal investigation. This will allow senior HR officers and line managers to make any decision on potential suspension or Police involvement. It will also allow discussion and agreement between the Head of Department/senior officer and HR regarding formal referral of the suspicion to the FLO. Once an agreement is reached, the suspicion and the grounds for that suspicion should be submitted to the FLO. If a suspicion relates to desirable medication or Controlled Drug (schedules 2, 3, 4 & 5) under the Misuse of Drugs Act 1971, the Controlled Drugs Accountable Officer* (who is also the Director of Pharmacy) should be contacted to enable a risk assessment to be undertaken.

* The roles and responsibilities of CDAOs are governed by the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

7.3 Where the suspicion relates to potential or actual fraud or corruption, information provided will be utilised by the FLO to populate a CFS1 form for formal referral of the matter to CFS who will consider the referral and take a view on whether a criminal investigation is justified.

7.4 For incidents involving Executive Directors of the Board, the FLO should contact the Chair of the Board or the Chair of the Audit and Risk Committee. It is important to act quickly when a suspicion is reported in order to minimise further losses to the Board. This also allows action to be taken to secure evidence required for any future proceedings; criminal or disciplinary.

7.5 Where the subject of the suspected theft, fraud, embezzlement, bribery or corruption is not an NHS colleague then the suspicion should be reported in writing to the Head of Department. It is important to capture as much information as is readily available regarding the person (or persons) suspected of fraud, theft or corruption for reporting to the FLO. The Head of Department and the FLO will then discuss and agree the most appropriate way forward, which may or may not include reporting the matter to Police Scotland and/or CFS.

7.6 For all instances where fraud or corruption is suspected a “nominated officer” will be appointed as the main point of contact for all stakeholders. For NHS Forth Valley, this officer is the FLO (see paragraph 5.1 above). In the absence of the FLO, the Deputy FLO will deal with the issue. For incidents involving any Executive Directors of the Board, the FLO will liaise with the nominated officer, who will be the Board Chairperson. It is important to act quickly when a suspicion is reported in order to minimise further losses to the Board and to allow action to be taken to secure any evidence that may be required for any future disciplinary or criminal proceedings.

7.7 CEL 44 (2008) updated the required reporting standards in a revised SFR 18 (Scottish Financial Return). The SFR 18 forms part of the Board’s annual accounts and the change was to improve reporting of all relevant items. The purpose of enhanced recording and reporting is to enable the Scottish Government and NHS bodies to better understand the scale and types of identified NHS frauds, the categories within which these fall, the amounts involved, where applicable (since not all frauds/attempted frauds reported will have an attributable cost), and recoveries made.

7.8 The FLO will maintain a log of any reported suspicions of fraud, theft or corruption. The log will document, with reasons, the decision to take further action or to take no further action. The log will also record any actions taken and conclusions reached. This log will be utilised to help populate the Boards SFR 18.2 form which forms part of the Board’s annual accounts.

7.9 The nominated officer (i.e the FLO) should consider the need to inform the NHS Forth Valley Board, the Counter Fraud Champion (CFC), the Chief Internal Auditor, External Audit, the Police and CFS, of the reported incident. In doing so, cognisance should be taken of the following guidance:

- Inform and consult the Director of Finance and the Chief Executive at the first opportunity, in all cases where the loss may exceed the delegated limit (or such lower limit as NHS Forth Valley may determine) or where the incident may lead to adverse publicity.
- In all cases where fraud, embezzlement, bribery, corruption or systematic thefts are suspected, it is essential that there is the earliest possible consultation with CFS, who should be contacted immediately by the FLO. CFS will then advise if Police Scotland need also be involved.
- In any event, CFS should be contacted before any overt action is taken that may alert suspects and precipitate the destruction or removal of evidence. This includes taking action to stop a loss or tighten controls.
- If a criminal act is suspected, particularly fraud or corruption, it is essential that there is the earliest possible consultation with the Police. The Police should be contacted before any overt action is taken which may alert suspects and precipitate the destruction or removal of evidence. This includes taking action to stop a loss or tighten controls.
- At the stage of contacting the Police, the FLO should contact the Director of Human Resources to consider whether/when to initiate suspension of the employee pending an enquiry.

7.10 All such contact should be formally recorded in the Log. It should be noted that staff who wish to raise concerns about unprofessional behaviour or decisions (where fraud, theft, embezzlement, bribery or corruption are not suspected) should do so by following

the guidance contained in the NHS Forth Valley Whistleblowing Policy. Following investigation of the complaint, if improper practices or criminal offences are suspected, the matter should be referred by the investigating officer to the FLO.

8. Managing the investigation

8.1 The decision on whether a referral is progressed by CFS as a criminal investigation is usually taken following correspondence between the FLO and CFS and usually involves an initial meeting to consider the available evidence. If the referral involves an employee of the Board then HR involvement in any initial meeting is crucial to avoid any conflict with ongoing or future disciplinary processes. The officer leading the criminal investigation will be Counter Fraud Specialist from CFS. The circumstances of each case will dictate who will be involved and when.

8.2 The manager overseeing the investigation (referred to hereafter as the "investigation manager") should initially:

- initiate a diary of events to record the progress of the investigation.
- if possible, determine the nature of the investigation i.e. whether fraud or another criminal offence. In practice it may not be obvious if a criminal event is believed to have occurred. If this is established the Police, External Audit and the Chief Executive should be informed if this has not already been done.

8.3 CFS staff, acting on behalf of the Director of Finance on any matters related to the investigation of fraud) are entitled without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case they shall have a duty to safeguard that confidentiality), within the confines of the data protection act;
b) Access at all reasonable times to any land, premises or employees of the Board;
c) The production or identification by any employee of any cash, stores or other property of the Board under an employee's control; and
d) Explanations concerning any matter under investigation.

8.4 If after initial CFS enquiries it is determined that there are to be no criminal proceedings then an internal investigation by NHS Forth Valley may be more appropriate. In this instance, all information/evidence gathered by CFS will be passed to NHS Forth Valley. The internal investigation will then be taken forward as appropriate in line with Employment Law, Once for Scotland policies and relevant HR policies such as the Management of Employee Conduct Policy.

8.5 Any formal internal investigation to determine and report upon the facts, should establish:

- the extent and scope of any potential loss.
- if any disciplinary action is required.
- the criminal or non-criminal nature of the offence (if not yet established).
- what can be done to recover losses.
- what may need to be done to improve internal controls to prevent any recurrence.

8.6 Where the report confirms a criminal act, and notification to the Police has not yet been made, then a formal report should be submitted to Police Scotland at that point.

8.7 This report should form the basis of any internal disciplinary action taken. The conduct of internal disciplinary action will be assigned to the Director of People or delegated officer within the Directorate, who shall gather such evidence as necessary.

8.8 Where recovery of a loss to NHS Forth Valley is likely to require a civil action, arising from any act (criminal or non-criminal), it will be necessary to seek legal advice through the Central Legal Office (CLO), which provides legal advice and services to NHS Scotland.

9. Disciplinary/dismissal procedures

9.1 Consideration should be made in conjunction with CFS/CFC/FLO on whether/when to suspend the employee(s) who are subject to any investigation, pending the results of the investigation.

9.2 In any disciplinary action taken by the NHS Forth Valley toward an employee, the Once for Scotland disciplinary procedures have to be followed (including dismissal). This may involve the person in charge of the investigation recommending a disciplinary hearing to consider the facts, reflect on the results of the investigation and recommendations on any further appropriate action, to the employee's line manager. Where the fraud involves, e.g. a regulated health professional, and/or a Primary Care Services Practitioner the Board should pass the matter over to the relevant professional body for action.

9.3 In every case where it is proposed to proceed to a disciplinary hearing whilst there is a criminal case pending based on the same or related allegations, the advice of Central Legal Office/external equivalent is to be sought before proceeding. There is no requirement under the criminal law for staff to be retained on full pay pending the criminal case. However, it may be considered inappropriate to proceed with a disciplinary hearing if the individual concerned declines to attend. In every such case, CLO will advise on whether the evidence is in itself sufficiently strong and compelling to justify dismissal in absentia, if necessary. In practice, such action will be the exception rather than the rule.

10. Gathering evidence

10.1 This policy cannot cover all the complexities of gathering evidence. Each case must be progressed based on the individual circumstances of the case, taking professional advice as necessary (including advice from CLO where deemed appropriate). Where CFS decides not to pursue a criminal investigation, for whatever reason, the recommended next steps may involve an internal, Board-level investigation. In these circumstances it is important that the gathering of evidence is carried out in a methodical and consistent way.

10.2 If a witness to the event is prepared to give a written statement, it is best practice for an experienced member of staff, preferably from the HR Directorate, to take a chronological record using the witness's own words. The witness should sign the statement only if satisfied that it is a true record of his or her own words. In

circumstances where the witness is the Fraud Liaison Officer then the “role” of Fraud Liaison Officer moves to the next most senior member of staff.

10.3 At all stages of the investigation, any discussions or interviews should be documented and where feasible agreed with the interviewee.

10.4 Physical evidence should be identified and gathered together in a secure place at the earliest opportunity. An inventory should be drawn up by the investigating officer and held with the evidence. To prevent any changes being made to the original evidence, where possible, a replacement or alternative record should be implemented for business continuity. It is essential that the evidence is kept intact. If evidence consists of several items, for example a number of documents, each one should be tagged with a reference number corresponding to the written record. Care with evidence gathering is important, as that which may initially be treated as a discipline case could become a criminal prosecution at a later stage.

10.5 Where evidence is believed to be held on: individual computers; laptops; smartphones; tablets; camera systems; or on a business network, CFS will provide advice in the first instance to the Board on developing a plan to secure digital evidence. Great care should be taken where there is a need to secure copies of files, emails and logs, and strict procedures must be followed to allow this type of evidence to be admissible in prosecution proceedings. Accessing this information prior to securing a forensic image may be considered by a Court as tampering with the evidence and it may be ruled inadmissible.

11. Disclosure of loss from fraud

11.1 Guidance on the referring of losses and special payments is provided in CEL 10 (2010) – Revised Scottish Financial Return (SFR) 18: Enhanced Reporting of NHS Frauds and Attempted Frauds. This includes reporting of all forms of irregular activity which suggest that fraud may have taken place, even if the evidence is not of a standard that can be used for prosecution. Scottish Financial Return (SFR) 18.0 on Losses and Compensation Payments is submitted annually to the Audit and Risk Committee as part of the Annual Accounts. SFR 18 should include all losses, with appropriate description, aligned within the standard categories specified by the SGHSCD. External Audit should be notified of any loss as part of their statutory duties.

11.2 Management must take account of the permitted limits on writing off losses for “Category 2 Boards”, as outlined in Annex C of CEL 10 (2010).

11.3 It will be important for the Director of Finance to consider actions to be taken to minimise the risk of a potential repeat of the incident. The actions could include a review of lessons learnt and completion of a risk assessment by internal audit or consideration of a Fraud Risk Assessment by CFS. Any lessons learned should for example, be disseminated to the Service through the internal audit network or by using the CFS bulletins.

12. Police Involvement

12.1 It is expected that, wherever a criminal act is suspected, but which falls out-with the remit of Counter Fraud Services, the matter will be notified to Police Scotland as follows:

- During normal working hours, it will be the decision of the Director of Finance as to the stage that the Police are contacted. If the Director of Finance is unavailable, this decision will be delegated to the FLO.
- Outwith normal working hours, the manager on duty in the area where a criminal act is suspected should always report the matter to the Senior Manager and Executive Director On Call. It will be the decision of the Executive Director On Call as to the stage that the Police are contacted. In any case the manager on duty in the area where a criminal act is suspected should always report the matter to the Director of Finance and the FLO at the earliest possible time.

12.2 The nominated officer (the FLO) and investigating manager should informally notify the Police of potential criminal acts, to seek advice on the handling of each investigation at an early stage in the investigation.

12.3 Formal notification of a suspected criminal act will normally follow completion of the investigating manager's report and formal disciplinary action. It is important that the internal report is carried out in a timely manner to avoid delaying the Police investigation.

13. Press Release

13.1 To avoid potentially damaging publicity to the NHS and/or the suspect, NHS Forth Valley should prepare at an early stage, a Press release, giving the facts of any suspected occurrence and any actions taken to date e.g. suspension. The Communications Team within CFS, the CLO and the Police should agree the release where applicable.

13.2 Under no circumstances should a member of staff speak or write to representatives of the press, TV or radio, about a suspected fraud without the express authority of the Chief Executive.

13.3 The Officer in Charge of the criminal case, whether from CFS or Police Scotland, will be responsible for collaborating with the Board's communications department in relation to preparing and agreeing the timing and content of an appropriate press release.

14. Resourcing any internal investigation

14.1 The Director of Finance will determine the type and level of resource to be used in investigating any suspected fraud. The choices available will include:

- Staff from within NHS Forth Valley
- Internal Audit
- Specialist Consultant
- Police

14.2 In making a decision, the Director of Finance, should consider independence, knowledge of the organisation, cost, availability and the need for a speedy investigation. Any decision must be shown in the Log held by the Nominated Officer (the FLO). A decision to take "No action" will not normally be an acceptable option unless exceptional circumstances apply.

14.3 In any case involving a suspected criminal act, it is anticipated that Counter CFS involvement will be in addition to NHS Forth Valley resources. In any case involving other suspected criminal acts, it is anticipated that Police involvement will be in addition to NHS Forth Valley resources.

15. The law and its remedies

15.1 Criminal Law - The Board shall refer all incidences of suspected fraud/criminal acts to CFS or the Police for decision by the Procurator Fiscal as to any prosecution.

15.2 Civil Law - The Board shall refer all incidences of loss through proven fraud/criminal act to the CLO for opinion, as to potential recovery of loss via Civil Law action.

15.3 Criminal Law may impose sanctions on the suspect for causing loss, while civil law may assist the Board to recover its loss.

Annex 1 – Key Contacts

Board Key Contacts

Role	Name	Designation	Contact Details
Fraud Liaison Officer	Anne Marie Machan	Regional Audit Manager	annemarie.machan@nhs.scot
Deputy Fraud Liaison Officer	Scott Urquhart	Director of Finance	01786 457245 scott.urquhart@nhs.scot
Counter Fraud Champion	Robert Clark	Non-Executive Member and Employee Director	01786 457226 robert.clark4@nhs.scot
Whistleblowing Champion	Gordon Johnston	Non-Executive Member and Whistleblowing Champion	Gordon.johnston@nhs.scot

External Contacts

Counter Fraud Hotline (Crimestoppers) – 08000 15 16 28

Counter Fraud Services – 01506 705200 (general enquiries)
www.nss.nhs.scot/departments/counter-fraud-services/

Independent National Whistleblowing Officer - 0800 008 6112
https://inwo.spso.org.uk/whistleblowing

SECTION E

Scheme of Delegation

1. INTRODUCTION

1.1. The Scheme of Delegation is a reference document which summarises the responsibilities and accountabilities of Forth Valley NHS Board and confirms the decision-making authority delegated by the NHS Board to standing committees, individual NHS Board members and NHS Board employees.

1.2. The Scheme of Delegation should be read in conjunction with the NHS Board's Code of Corporate Governance and Financial Operating Procedures.

1.3. The Scheme of Delegation is a key part of the NHS Board's governance framework and is designed to support timely and effective decision making across the organisation. As a minimum, the Scheme of Delegation is subject to an annual review by the NHS Board. However, the scheme may be reviewed more frequently where appropriate (for example following a change in the management or organisational structure that is likely to impact on the scheme's effectiveness).

1.4. The NHS Board has delegated authority to the Director of Finance to lead the routine review and maintenance of the Scheme of Delegation.

2. PRINCIPLES UNDERPINNING DELEGATION AND DECISION MAKING

2.1. All members and officers of the NHS Board are expected to familiarise themselves with the Scheme of Delegation.

2.2. In accordance with Financial Operating Procedure 03, all budget holders are required to formally agree their annual budgets and are accountable for budgetary performance. It is essential that expenditure levels do not exceed the agreed budget. Budget holders must therefore ensure that all decisions taken within the scope of their delegated authority are affordable within the available budget.

2.3. Where an employee of a Local Authority is either a budget holder or is granted authority to approve expenditure, the Director of Health and Social Care (IJB Chief Officer) must ensure that this individual is familiar with the NHS Board's policies and procedures and has the necessary access to relevant IT systems.

2.4. Where authority is delegated to Directors and members of the Senior Management Team, further delegation to deputies and other staff may be permitted through the Authorised Signatory process. However, the Directors and members of the Senior Management Team named in the Scheme of Delegation ultimately remain accountable for the actions of any individuals they have delegated to and for all transactions within their remit. Note that there are certain transactions and activities that may not be delegated any further (these items can only be approved by the named Director or member of the Senior Management Team in the Scheme of Delegation).

2.5. All values quoted in the Scheme of Delegation are inclusive of VAT, unless otherwise stated.

3. MATTERS RESERVED FOR THE NHS BOARD

3.1. The NHS Board is ultimately responsible for the protection and improvement of the health of Forth Valley's resident population and for the delivery of local frontline healthcare services.

3.2. The Standing Orders contained in the Code of Corporate Governance sets out the written rules on the business conduct and proceedings of the NHS Board. In accordance with section A, paragraph 6 and annex C of the Standing Orders, decision making on the following matters is reserved exclusively for the NHS Board and these matters may NOT be delegated:

3.2.1. The establishment and terms of reference of all its committees, and appointment of committee members.

3.2.2. Organisational Values.

3.2.3. The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.

3.2.4. The Delivery Plan for submission to the Scottish Government for its approval. (Note: The Board should consider the draft for submission in private session. Once the Scottish Government has approved the Delivery Plan, the Board should receive it at a public Board meeting).

3.2.5. Corporate objectives or corporate plans which have been created to implement its agreed strategies.

3.2.6. Risk Management Policy.

3.2.7. Financial plan for the forthcoming year, and the opening revenue and capital budgets and medium-term financial planning (3 – 5 year plans).

3.2.8. Standing Financial Instructions and the Scheme of Delegation.

3.2.9. Annual accounts and report. (Note: This must be considered when the Board meets in private session. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts, or any information drawn from it before the accounts are laid before the Scottish Parliament. Similarly, the Board cannot publish the report of the external auditors of their annual accounts in this period).

3.2.10. Approval of local business cases with a revenue or capital value of in excess of £250k.

3.2.11. Endorsement of any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval (the current delegated limit set by the Scottish Government for NHS Forth Valley is £1.5m as per the Scottish Capital Investment Manual and CEL(2010)32).

3.2.12. The Board shall approve the content, format, and frequency of performance reporting to the Board.

3.2.13. The appointment of the Board's chief internal auditor. (Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The audit committee should advise the Board on the appointment, and the Board may delegate to the audit committee oversight of the process which leads to a recommendation for appointment).

3.2.14. Acquisition and disposal of any land and property in excess of £250,000.

3.2.15. NHS Board Members' Register of Interests.

3.2.16. Approval of NHS Board Annual Report and Annual Accounts.

3.2.17. Financial and Performance Management Reporting Arrangements.

3.2.18. Arrangements for approval of policies required as a result of national guidelines with the exception of Human Resource policies (see Staff Governance Committee remit).

3.2.19. Recommendations to the Scottish Government relating to the closure or change of use of hospitals.

3.2.20. Appointment of Executive Directors of Forth Valley NHS Board.

3.2.21. Appointment of Management Consultants/Advisors where contract value exceeds £100,000.

3.2.22. Approval of delegation of any function to an agency out with the National Health Service.

4. MATTERS DELEGATED TO STANDING COMMITTEES AND GROUPS

4.1 In accordance with section A, paragraph 7 of the Standing Orders, the NHS Board may delegate decision making to standing committees and various groups as appropriate. The following standing committees and groups have delegated responsibility for decision making on behalf of the NHS Board.

4.2 **Matters delegated to standing committees:**

4.2.1. **Audit and Risk Committee** (Executive Lead: Director of Finance). Decision making by this Committee is focused on matters relating to risk management, governance and internal control as part of the Committee's key role to provide assurance that the organisation is being managed effectively and resources are safeguarded appropriately.

4.2.2. **Clinical Governance Committee** (Executive Leads: Medical Director and Executive Nurse Director). Decision making by this Committee primarily relates to service quality assurance, continuous service improvement and clinical risk management as part of the Committee's role to ensure effective Clinical Governance arrangements are in place throughout the local NHS system (including services that are commissioned from independent providers and other partner agencies)

4.2.3. **Strategic Planning, Performance and Resources Committee** (Executive Lead: Director of Finance). Decision making by this Committee is linked to all aspects of performance management (both financial and non-financial) and securing best value in the use of resources (including approval of property transactions).

4.2.4. **Pharmacy Practices Committee** (Executive Lead: Medical Director). This Committee will consider and approve or reject applications for inclusion in the Pharmaceutical List in accordance with the NHS (Pharmaceutical Services) (Scotland) Regulations 2009 and the NHS (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 (SSI 2011 No. 32) and 2014 (SSI 2014 No. 148).

4.2.5. **Remuneration Committee** (Executive Lead: Director of People). Decision making by this Committee is focused on the application and implementation of fair and equitable pay systems on behalf of the NHS Board, as determined by Ministers and Scottish Government.

4.2.6. **Staff Governance Committee** (Executive Lead: Director of People). Decision making by this Committee primarily relates to implementation of the NHS Scotland staff governance standard.

4.3 Further information on the specific role and remit of each of the standing committees referred to above is contained in section A, annex B of the NHS Board's code of corporate governance.

4.4 **Matters delegated to Groups:**

4.4.1. **Senior Leadership Team** (SLT) - the SLT is the whole system decision making group for the implementation of the NHS Board's strategy. SLT has accountability through the Chief Executive to the NHS Board and reports to the NHS Board.

4.4.2. The role and remit of the SLT is:

Role and Remit of the Senior Leadership Team
Providing exemplary leadership and direction to the organisation, modelling the principles, behaviours and values set out in the NHS Forth Valley Code of Conduct.
The development, implementation and co-ordination of operational plans, policies, procedures and resources that underpin the delivery of the Board's strategic aims, particularly complex whole system decisions.
The oversight and monitoring of the whole system and its performance across all strands of delivery, holding each other to account through effective performance accountability structures.
Prioritising and allocating resources through transparent processes. For example, the group will consider for approval all business cases seeking capital and revenue investment in excess of £50k that have been endorsed by the Strategic Prioritisation Review & Implementation Group (SPRIG).

Assessing and mitigation of risk, in conjunction with active horizon scanning for opportunities.
Ensuring that the regulatory and statutory requirements are met for the Board.

5. MATTERS DELEGATED TO INDIVIDUALS

5.1 The Chief Executive:

5.1.1. The Chief Executive, as the Accountable Officer of the NHS Board in line with Part 2, Section 15 of the Public Finance and Accountability (Scotland) Act 2000, is personally answerable to the Scottish Parliament in respect of the NHS Board's policies, actions and conduct. Financial Operating Procedure 02 and the NHS Board's Standing Financial Instructions provide further detail on the specific responsibilities of the Chief Executive.

5.1.2. The full range of responsibilities arising from the NHS Board's Standing Orders and Standing Financial Instructions in relation to financial, corporate and clinical governance, risk management and other operational activities are delegated to other specific individuals as summarised in the following tables.

5.2 Delegated Powers Arising from Standing Orders

Ref	Area of responsibility	Delegated to	Further delegation permitted	Limits applying £	Comments
Delegated powers arising from Standing Orders					
5.2.1	Maintenance of a register of NHS Board members interests.	Board Secretary	N/A	N/A	As per section 1.6 of the NHS Board's Standing Orders. As a minimum, the register is updated on an annual basis and this is published online.
5.2.2	Execution of documents on behalf of Scottish Ministers relating to property transactions.	Chief Executive and/or Director of Finance	N/A	N/A	As per section 8.1 of the NHS Boards Standing Orders. Also see the NHS Scotland Property Transactions Handbook for further information.
5.2.3	Sealing of documents with the NHS Board Seal	Chief Executive and/or Director of Finance	N/A	N/A	Use of the NHS Board seal must be accompanied by the signatures specified in the Standing Orders.

5.3 Delegated Powers Arising from Standing Financial Instructions:

Ref	Area of responsibility	Delegated to	Further delegation permitted	Limits applying £	Comments
Delegated powers arising from Standing Financial Instructions					
ALLOCATIONS, BUSINESS PLANNING, BUDGETS & BUDGETARY CONTROL					
5.3.1	Design, implement & monitor systems of financial control & related procedures (including establishment & maintenance of financial planning & the budgetary control system).	Director of Finance	N/A	N/A	In accordance with section 1.1.4 of the NHS Board's Standing Financial Instructions & Statutory Instrument (1974) no 468 & NHS circular 1974 (GEN) 88.
5.3.2	Preparation of revenue and capital financial plans.	Director of Finance	N/A	Revenue Resource Limit & Capital Resource Limit	Approval of the annual financial plan is initially required by the Strategic Planning, Performance & Resources Committee, followed by the NHS Board. The financial plan will normally be approved by SPP&R committee in February & the NHS Board in March, (ie the plan must be approved in advance of the financial year to which it relates).
5.3.3	Calculation of the annual payment to Integration Joint Boards (IJBs)	Director of Finance	N/A	As per approved financial plan	Forms part of the annual financial plan & must be approved by the NHS Board in line with the timescales indicated in the relevant Integration Scheme. See 5.3.84 re approvals.
5.3.4	Annual budget setting & allocation of **non-delegated** revenue healthcare service budgets to budget holders.	Director of Finance	Deputy Director of Finance	As per approved financial plan	Also referred to as NHS Core Service budgets. As per Financial Operating Procedure (FOP) 03 all budget holders are required to formally agree their annual budgets, together with any in year changes, through an authorised Budget Control Amendment schedule.
5.3.5	Annual budget setting & allocation of **delegated** set aside & integrated revenue healthcare service budgets to budget holders in the Health & Social Care Partnership (HSCP).	Chief Finance Officer	N/A	As per approved IJB financial plan	Integrated budget is also referred to as Operational and Universal HSCP service budgets. Budgets must reconcile to IJB Directions & confirmation from Chief Finance Officer (CFO).

5.3.6	In year management of revenue **non-delegated** budgets at individual budget level (pay & non-pay) and overall service level.	Nominated budget holders/ relevant Director	Named Deputies	Within approved budget	All budget holders have a responsibility to ensure expenditure is contained within agreed budgeted levels. A list of budget holders in maintained by the Director of Finance.
5.3.7	Budget virement within or between **non-delegated** revenue healthcare service budgets.	Relevant Director	Deputy Director of Finance	< £100k	Any proposed virement must be in support of agreed NHS Board strategy. Virement over £100k requires approval from the Director of Finance.
5.3.8	Authority to commit expenditure for which no provision has been made in approved financial plans/budgets.	Chief Executive	Director of Finance	£500k	Limit applies to both revenue and capital expenditure.
5.3.9	Authority to commit expenditure for which no provision has been made in approved financial plans/budgets.	Director of Finance	N/A	£250k	Limit applies to both revenue and capital expenditure.
5.3.10	Budget virement within or between **non-delegated** revenue healthcare budgets in respect of items where no provision has been made in approved financial plans/budget.	Director of Finance	Deputy Director of Finance	£100k	In general budgets should only be used for the purposes originally intended & agreed. Any virement (regardless of value) to fund an item that is not provided for or agreed via the financial plan or budget requires approval from the Director of Finance.
5.3.11	In year management of revenue **delegated** set aside & integrated healthcare budgets at individual budget level and overall service level.	HSCP Nominated budget holders/Chief Officer/ Director of Acute Services	Named Deputies	Within approved budget	All budget holders have a responsibility to ensure expenditure is contained within agreed budgeted levels. Budget management processes and risk sharing arrangements are outlined in the extant Integration Schemes.
5.3.12	Budget virement within or between **delegated** integrated revenue healthcare service budgets.	Chief Officer	N/A	< £100k	Any proposed virement of HSCP operational or universal budgets must be in support of agreed IJB strategy. See IJB Scheme of Delegation for further information.

5.3.13	Budget virement to/from **delegated** Set Aside revenue healthcare service budgets or virement between Set Aside & the Integrated budget.	Director of Finance & Chief Officer	Deputy Director of Finance & Chief Finance Officer	< £100k	Any proposed virement within Set Aside budgets, or transfers to/from Set Aside & integrated budgets be in support of agreed IJB strategic plans.
5.3.14	Annual budget setting & allocation of Capital budgets to budget holders.	Director of Finance	Deputy Director of Finance	As per of approved financial plan	Capital budgets are allocated based on the NHS Board approved 5-year capital plan.
ANNUAL ACCOUNTS & REPORTS					
5.3.15	Submission of Financial Performance Returns to Scottish Government.	Director of Finance	Deputy Director of Finance	N/A	Monthly in line with the Scottish Government reporting timetable.
5.3.16	Signatories to Annual Report & Accounts/Financial Statements.	Chief Executive and Director of Finance	N/A	N/A	Draft accounts to be submitted to the Scottish Government by 31 May followed by final audited accounts no later than 30 June as per the NHS Scotland Annual Accounts Manual and Public Finance & Accountability (Scotland) Act 2000. Formal approval of the audited Annual Report & Accounts is via the NHS Board.
5.3.17	Preparation of Annual Governance Statement.	Director of Finance	Deputy Director of Finance	N/A	The Annual Governance Statement forms part of the Accountability Report section of the Annual Report & Accounts. See NHS Scotland Annual Accounts Manual for further information.
AUDIT					
5.3.18	Appointment of External Auditor.	Auditor General	N/A	N/A	The External auditors of the NHS Board are appointed by the Auditor General on a five-year cycle in order to maintain auditor independence. The majority of external audits are undertaken by Audit Scotland with the balance carried out by private firms of auditors appointed by the Auditor General. See Audit Scotland code of Audit Practice & International Standard on Auditing (IAS) 315 for further information.
5.3.19	Appointment of Chief Internal Auditor.	NHS Board	N/A	N/A	As per section 6.2 of the NHS Board's Standing Orders.

5.3.20	Provision of an adequate Internal Audit Service.	Director of Finance	N/A	N/A	As per section 15 of the Standing Financial Instructions and Public Sector Internal Audit Standards (PSIAS).
5.3.21	Preparation of annual audit certificate	External Auditor	N/A	N/A	The Annual Audit Report (ISA 260) & annual audit certificate are prepared by External Audit & presented to those charged with governance (via the Audit & Risk Committee) in June of each year.
BANKING ARRANGEMENTS					
5.3.22	Opening of bank accounts in the NHS Board's name	Director of Finance	N/A	N/A	Cash balances in non-GBS accounts held with commercial banks must not exceed £50k as per HDL(2001)49.
5.3.23	Notification to Bankers of authorised signatories on bank accounts	Director of Finance	Deputy Director of Finance	N/A	The Accounting Services Manager will maintain a list of authorised signatories for all banking services.
5.3.24	Transfers to/from Government Banking Service (GBS) accounts to commercial accounts	Director of Finance	Deputy Director of Finance	N/A	Working capital and cash flow is managed by the Treasury team under the direction of the Director of Finance. Temporary cash surpluses shall only be held in accordance with the Scottish Public Finance Manual (SPFM).
5.3.25	Authorisation of BACS, CHAPS, SWIFT, faster payments	2 signatories from list of bank authorisers	N/A	N/A	As per authorised signatory list referred to in 5.3.23. • Bankers Automated Clearing System (BACS), • Clearing Houses Automated Payment System (CHAPS) • Society for World-wide Interbank Financial Telecommunication (SWIFT)
5.3.26	Authorisation of Direct Debits and Standing Order mandates	Director of Finance	Deputy Director of Finance	N/A	
5.3.27	Authorisation of corporate credit card transactions.	Deputy Director of Finance	Accounting Services Manager	N/A	Transactions must be pre-approved by the relevant budget holder (and/or Director of Finance depending on value) before being processed by the Treasury Team.

SERVICE LEVEL AGREEMENTS & CONTRACTS REALTING TO THE PROVISION OF HEALTHCARE					
5.3.28	Signing of Service Level Agreements (SLAs) & contracts for the provision of healthcare	Director of Finance & relevant Director	N/A	Within approved budget	All SLAs & provision of service contracts for healthcare, regardless of the value, must be jointly signed by the Director of Finance and relevant service Director on behalf of the NHS Board.
5.3.29	Setting of fees & charges in respect of private patients, overseas visitors, income generation/mutual aid and other patient related services.	Director of Finance	Deputy Director of Finance	N/A	Applies in respect of fees that are locally determined and are not set by Scottish Government/statute.
5.3.30	Submission of grant applications and funding bids	Director of Finance & relevant Director	N/A	N/A	All grant applications and funding bids must be approved by the Director of Finance in advance of submission to the awarding body.
5.3.31	Signing of Patient Access Scheme (PAS) & Primary Care Rebate Scheme (PCRS) approval letters	Director of Pharmacy	N/A	N/A	PAS & PCRS are confidential pricing agreements between the NHS Board & pharmaceutical companies designed to enable patients to gain access to drugs or other treatments that may not be considered to be cost-effective based on published list price. NHS National Services Scotland maintain a PAS and PCRS register on behalf of all NHS Boards.
PAY EXPENDITURE					
5.3.32	Preparation of contracts of employment	Director of People	Yes	N/A	Contacts must comply with relevant legislation & national and/or locally agreed terms & conditions as advised by HR. The post must form part of the budgeted establishment.
5.3.33	Approval of hours worked & leave/absence recording	Budget holder	Line Manager	Within approved budget	Hours worked and absence for all staff groups must be within budget, in line with relevant Terms & Conditions & recorded via the appropriate HR & payroll systems eg Scottish Standard Time System (SSTS), electronic Employee Support System (eESS) and eRoster/Allocate.

5.3.34	Engagement of supplementary staffing & other external contractors/workers	Executive Nurse Director/ Medical Director	Nurse Director/ Associate Medical Director	N/A	See agreed approval processes/protocols for the use of supplementary medical & dental and Nursing, Midwifery & Allied Health Professionals (NMAHP). The recruiting manager must conduct IR35/off payroll working checks in advance of engaging certain external contractors and workers as appropriate.
5.3.35	Approval of new and/or redesigned posts or regraded posts	Director of People/ Director of Finance	N/A	Within approved budget	Professional advice and approval must be confirmed in relation to any skill mix change or regrading (see section 5 of the Recruitment Authorisation Form). The post must form part of the budgeted establishment.
5.3.36	Responsibility for implementing changes to terms & conditions of service	Director of People	Named Deputies	N/A	As per national guidance & policy.
5.3.37	Approval of severance and/or settlement agreements/exit packages	Chief Executive	Director of People	≤ £95k	Packages in excess of £95k require to be approved by the Scottish Government in line with DL(2019)15 and the SPFM.
5.3.38	Settlement of employment litigation claims	Director of People	N/A	≤ £100k	In conjunction with advice from the Central Legal Office (CLO). Values in excess of £100k require Scottish Government Approval.
NON-PAY EXPENDITURE (REVENUE)					
5.3.39	Development & oversight of Procurement Strategy	SPP&RC	Head of Procurement	N/A	Procurement activity must be conducted in accordance with the requirements of the SPFM and all relevant procurement legislation and regulations as they apply to the NHS in Scotland.
5.3.40	Maintenance of a non-pay contract register	Head of Procurement	N/A	N/A	
5.3.41	Approval & authorisation of non-pay revenue expenditure, including supplier invoices, employee expense claims etc	Relevant Budget Holder	Named deputies	Within approved budget	Limits for each budget holder are contained in the authorised signatory list maintained by the Accounting Services Team. Expenditure authorised by the budget holder must be contained within the available budget.

					Approval of employee expense claims must be in line with agreed Terms & Conditions of service and within the available budget.
5.3.42	Management & control of stock – including issue of stores recording & operating procedures.	Head of Procurement/ Digital Director/ Pharmacy Director	N/A	N/A	Stock security arrangements also fall under this item (including management of controlled drugs see item 5.5.8)
5.3.43	Amendments to the Unitary Charge in relation to PFI/PPP contracts as a result of a variation request where the associated revenue costs are less than £20k	Director of Facilities & Director of Finance	N/A	≤ £20k	See contract variation request process – if the variation request is cost neutral or the additional revenue costs are less than £20k, acceptance of the response to the variation request requires to be approved by both the Director of Facilities and the Director of Finance.
5.3.44	Amendments to the Unitary Charge in relation to PFI/PPP contracts as a result of a variation request where the associated revenue costs are in excess of £20k	Strategic Planning, Performance & Resources Committee.	N/A	>£20k	See contract variations process. Where the additional revenue costs of the variation request are greater than £20k, a business case should be presented to the Strategic Planning, Performance & Resources Committee for approval (this may require NHS Board approval if costs exceed £250k).
NON-PAY EXPENDITURE (CAPITAL)					
5.3.45	In year management of capital budgets at individual project level & Directorate level.	Budget holder/ Director	Named deputies	Within approved budget	All budget holders have a responsibility to ensure expenditure is contained within agreed budgeted levels.
5.3.46	Virement of capital budget between projects (per item/event)	Digital Director/ Director of Facilities	DDOF	≤ £150k	Subject to affordability. Proposed virement in excess of £150k requires approval by the Director of Finance (Chief Exec where value is over £250k & NHS Board where value is in excess of £500k).
5.3.47	Management of capital contingency budget	Director of Finance	DDOF	Within approved budget	All budget holders have a responsibility to ensure expenditure is contained within agreed budgeted levels. Virement permitted within agreed levels.

5.3.48	Approval of non-pay capital expenditure, including supplier invoices etc.	Relevant Budget Holder	Named Deputies	Within approved budget	As per 5.3.41 above re authorised signatory.
5.3.49	Amendments to the Unitary Charge in relation to PFI/PPP contracts as a result of a variation request where the associated capital costs are in excess of £20k	Strategic Planning, Performance & Resources Committee	N/A	>£20k	As per 5.3.43 & 5.3.44 above. Variations with a capital cost below £20k can be approved by the Director of Facilities and Director of Finance (both signatures are required on the variation acceptance). Where capital costs exceed £20k approval is via the SPPRC.
ORDERS, QUOTATIONS & TENDERS					
5.3.50	Responsibility for ensuring that all expenditure is processed via official purchase orders (PO)	Budget holders	Yes	Within approved budget	NHS Forth Valley POs are subject to our standard terms of business unless otherwise agreed in writing. “No PO no pay” policy applies (ie all supplier invoices must quote a valid PO number).
5.3.51	Requisitioning & ordering of goods & services: Where an order exceeds a 12-month period	DDOF	No	Within approved budget	Subject to total expenditure remaining within the approved budget.
5.3.52	Requisitioning & ordering of goods & services (**revenue**): With an annual value up to £250k	Relevant Director	DDOF	≤ £250k	Subject to total expenditure remaining within the overall budget allocated to the Directorate.
5.3.53	Requisitioning & ordering of goods & services (**revenue**): With an annual value over £250k	Chief Executive	Director of Finance	≥ £251k	Subject to total expenditure remaining within the overall approved NHS Board budget.
5.3.54	Requisitioning & ordering of goods & services (**capital**): With an annual value over £500k	Chief Executive	Director of Finance	≥ £500k	Subject to NHS Board approval of the associated business case (including confirmation that all capital & revenue consequences are affordable) and/or the NHS Board approved capital plan.
5.3.55	Requisitioning & ordering of goods & services (**capital**): With an annual value up to £499k	Digital Director/ Director of Facilities	Deputy Director of Finance	£250k to £499k	Subject to NHS Board approval of the associated business case (including confirmation that all capital & revenue consequences are affordable) and/or the NHS Board approved capital plan.

5.3.56	Requirements for quotations & tenders: Where the value of the expenditure is between £5,000 toto £10,000 a minimum of 1 written quotation should be sought.	Budget holders	No	Within approved budget	The written quotation can be via hard copy or electronic. Consider use of "Quick Quote" where appropriate. This is an online quotation facility via the Public Contracts Scotland website which enables NHS Boards to obtain competitive quotes electronically for low value requirements.
5.3.57	Requirements for quotations & tenders: Where the value of the expenditure is between £10,001 to £19,999 a minimum of 2 written quotations should be sought.	Budget holders	N/A	Within approved budget	As above.
5.3.58	Requirements for quotations & tenders: Where the value of the expenditure is between £20,000 to £50,000 a minimum of 3 written quotations should be sought.	Budget holders	N/A	Within approved budget	As above.
5.3.59	Requirements for quotations & tenders: Where the value of the expenditure is greater than £50,000 a competitive tender process is required.	Budget holders	N/A	Within approved budget	As per the Procurement Reform (Scotland) 2014 Act 2014, any contracts over £50k (for goods and services) or £2m (for works) must be formally advertised on the Public Contracts Scotland website. These thresholds are exclusive of VAT. Contact the Head of Procurement for further advice on the competitive tender process.
5.3.60	Maintenance of tender register	Head of Procurement	N/A	N/A	
5.3.61	Approval of Tender Waivers	Director of Finance	Deputy Director of Finance	N/A	As per Tender Waiver form.
5.3.62	Maintenance of tender waiver register	Director of Finance	Deputy Director of Finance	N/A	A summary of all tender waivers approved by the Director of Finance approved during the financial year is reported on an annual basis to the Audit & Risk Committee.
CAPITAL INVESTMENT & RELATED TRANSACTIONS					

5.3.63	Approval of Business Cases	NHS Board	N/A	≥ £250k	Business cases with a capital value in excess of £1.5m also require formal approval by the Scottish Government.
5.3.64	Approval of the acquisition or disposal of land & property where the sales proceeds or Net Book Value is in excess of £250k	NHS Board	N/A	≥ £250k	For disposals, the land or property must be formally declared surplus to requirements. Note that all land & property transactions must be endorsed by the Strategic Planning, Performance & Resources Committee (SPPRC) to provide assurance that the requirements of the NHS Scotland Property Transactions Handbook have been met.
5.3.65	Approval of the acquisition or disposal of land & property where the sales proceeds or Net Book Value is less than £250k	Director of Finance	N/A	≤ £250k	As above
5.3.66	Approval to condemn & dispose of assets (excluding land & property) where the current/estimated purchase price is in excess of £250k	Chief Executive	Director of Finance	≥ £250k	This applies to items that are obsolete, redundant, irreparable or cannot be repaired cost effectively.
5.3.67	Approval to condemn & dispose of assets (excluding land & property) where the current/estimated purchase price is £20k to £250k	Director of Finance	Deputy Director of Finance	£20k to £250k	As above
5.3.68	Approval to condemn & dispose of assets (excluding land & property) where the current/estimated purchase price is up to £20k	Relevant Director	Deputy Director of Finance	£20k	As above
5.3.69	Approval to enter into lease/rental agreements where the NHS Board is the lessee/tenant (including concessionary leases)	NHS Board	N/A	N/A	Requires endorsement by the Strategic Planning, Performance & Resources Committee (SPPRC) to provide assurance that the requirements of the NHS Scotland Property Transactions Handbook have been met. All lease/rental agreements require approval by the NHS Board.
5.3.70	Approval to enter into lease/rental agreements where the NHS Board is the lessor/landlord (including	NHS Board	N/A	N/A	Subject to formal tenancy/occupancy agreements being in place as prepared by the Director of Facilities & approval of rent by Deputy

	concessionary leases granted to voluntary, community or social enterprise groups)				Director of Finance. All lease/rental agreements require approval by the NHS Board.
ENDOWMENT FUNDS (FORTH VALLEY GIVING)					
5.3.71	Approval of the annual budget in respect of both restricted & unrestricted funds.	Endowment Trustees	N/A	N/A	As recommended/endorsed by the Endowment subcommittee.
5.3.72	Approval of expenditure from endowments funds (including both restricted & unrestricted funds)	Endowment Trustees	N/A	Within approved budget	As recommended/endorsed by the Endowment subcommittee.
5.3.73	Maintenance of Accounts & associated records	Director of Finance	Deputy Director of Finance	N/A	Note that the endowment funds are subject to an annual external audit. The external auditors are formally appointed by the Endowment Trustees.
5.3.74	Access to share and stock certificates and property deeds	Director of Finance	Deputy Director of Finance	N/A	
5.3.75	Opening and amendment of bank accounts in name of the NHS Forth Valley Endowment Fund, a registered charity administered under the terms of sections 82, 83 and 84A of the National Health Service (Scotland) Act 1978.	Director of Finance	Deputy Director of Finance	N/A	The opening & amendment of such bank accounts is to be reported to the Endowment Trustees.
5.3.76	Acceptance and banking of endowment funds	Director of Finance	Deputy Director of Finance	N/A	Funds may only be accepted where they are in line with the charitable purpose of the endowment fund as per the NHS Forth Valley Health Board Endowment Fund Charter.
5.3.77	Investment of Endowment Funds	Endowment Trustees	N/A	As per Strategy	As per Investment Strategy approved by the Endowment Trustees.
5.3.78	Nominee for grants of probate or letters of administration for an estate.	Director of Finance	N/A	N/A	Where appropriate to obtain a legacy left to the Endowment Fund under the terms of a will.
FAMILY HEALTH SERVICES (FHS)					

5.3.79	Preparation, issue & agreement of 17J & 17C General Medical Services (GMS) Contracts	Director of Falkirk Health & Social Care Partnership	Primary Care Contracts Manager/ Deputy Director of Finance	N/A	Operationally managed on behalf of the NHS Board by the Director of Health & Social Care (Falkirk). Note that this is not a delegated service for the purposes of Health & Socia Care integration as IJBs cannot hold contracts.
5.3.80	Monitoring of FHS contracts	Director of Falkirk Health & Social Care Partnership	Primary Care Contracts Manager	N/A	As above in terms of operational management. Monitoring of contracts for all FHS contractor streams is undertaken by the FHS Performance Review Group. Reports on issues arising (including potential fraud) are received by the Audit & Risk Committee.
5.3.81	Additions & removals from NHS Forth Valley FHS performer lists	Primary Care Contracts Manager	Deputy Director of Finance	N/A	As per the National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004.
5.3.82	Pre & post payment verification (PV) of payments made to all FHS contractors.	Practitioner & Counter Fraud Services NHS NSS on behalf of NHS Forth Valley	N/A	As per PV protocol	In line with the national PV protocol DL(2023)24
HEALTH & SOCIAL CARE INTEGRATION					
5.3.83	Delegation of Functions to Integration Joint Boards (IJBs)	NHS Board	N/A	N/A	In accordance with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.
5.3.84	Approval of payments to IJBs	NHS Board	N/A	Within approved budget	As per NHS Board approved financial plan.
FRAUD, LOSSES, LEGAL CLAIMS & SPECIAL PAYMENTS					
5.3.85	Ex-gratia payments: • Extra-contractual payments • Compensation payments (Clinical)	Director of Finance	N/A	≤£15K ≤£250k	Ex-gratia payments above these limits requires approval from the Scottish Government. See Scottish Financial Return (SFR) 18.1a "Details of Delegated Authority of NHS Boards

	• Compensation payments (Non-Clinical) • Compensation payments (Financial Loss) • Other payments			≤£100k ≤£25k ≤£2k	for Losses and Special Payments" for Category 2 Boards.
5.3.86	Legal claims – clinical	NHS Board	Chief Executive (for urgent decisions between Board meetings)	≤ £250k	Scottish Government approval is required for clinical claims in excess of £250k together with clinical approval by the Medical Director as per SFR 18.1a.
5.3.87	Legal claims – non-clinical	Chief Executive	Director of Finance	≤ £100k	Both NHS Board and Scottish Government approval is required for non-clinical claims in excess of £100k as per SFR 18.1a.
5.3.88	Theft/Arson/Wilful Damage: • Cash • Stores / procurement • Equipment • Contracts • Payroll • Buildings & Fixtures • Other	Director of Finance	N/A	≤£15k ≤£30k ≤£15k ≤£15k ≤£15k ≤£30k ≤£15k	Losses or payments relating to Theft, Arson or Wilful Damage above these limits requires approval from the Scottish Government as per SFR 18.1a.
5.3.89	Fraud, Embezzlement & other irregularities (including attempted fraud): • Cash • Stores / procurement • Equipment • Contracts • Payroll • Other	Director of Finance	N/A	≤£15k ≤£30k ≤£15k ≤£15k ≤£15k ≤£15k	Losses or payments relating to Fraud, Embezzlement & other irregularities (including attempted fraud) above these limits requires approval from the Scottish Government as per SFR 18.1a.
5.3.90	Nugatory & Fruitless Payments	Director of Finance	N/A	≤£15k	Nugatory & Fruitless Payments above this limit requires approval from the Scottish Government as per SFR 18.1a.

5.3.91	Claims Abandoned: • Private Accommodation • Road Traffic Acts • Other	Director of Finance	N/A	≤£15k ≤£30k ≤£15k	Claims Abandoned above these limits requires approval from the Scottish Government as per SFR 18.1a.
5.3.92	Stores losses due to: • Fire • Flood • Accident • Deterioration in Store • Stocktaking Discrepancies • Other Causes		N/A	≤ £30k	Stores losses above this limit requires approval from the Scottish Government as per SFR 18.1a.
5.3.93	Losses of Furniture & Equipment and Bedding & Linen in circulation due to: • Fire • Flood • Accident • Disclosed at physical check • Other Causes	Director of Finance	N/A	≤ £15k	Losses of Furniture & Equipment and Bedding & Linen in circulation above this limit requires approval from the Scottish Government as per SFR 18.1a.
5.3.94	Damage to Buildings & Fixtures due to: • Fire • Flood • Accident • Other Causes	Director of Finance	N/A	≤ £30k	Damage to Buildings & Fixtures above this limit requires approval from the Scottish Government as per SFR 18.1a.
5.3.95	Gifts in cash or in kind	Director of Finance	N/A	≤ £15k	Gifts in cash or in kind above this limit requires approval from the Scottish Government as per SFR 18.1a.
5.3.96	Other losses not included in the categories above	Director of Finance	N/A	≤ £15k	Other losses above this limit require approval from the Scottish Government as per SFR 18.1a.

5.4 Delegated Powers Arising from Other Areas of Corporate Governance:

Ref	Area of responsibility	Delegated to	Further delegation permitted	Limits applying £	Comments
Delegated powers arising from other areas of corporate governance					
CLINICAL GOVERNANCE					
5.4.1	Approval of Clinical Governance Strategy	NHS Board	Clinical & Care Governance Committee	Within approved budget	Executive Lead: Medical Director
5.4.2	Approval of research & development studies, including associated clinical trials & indemnity agreements in respect of commercial studies	Medical Director	N/A	Within approved budget	Initial approval is through the Research & Ethics Committee (this group will prepare an annual report for the Clinical & Care Governance Committee).
5.4.3	Approval of Quality Strategy	NHS Board	Clinical & Care Governance Committee	Within approved budget	See FV-Quality-Strategy-2021-2026.pdf Executive Lead: Medical Director
5.4.4	Approval of patient complaints handling policy & procedures	Clinical & Care Governance Committee.	Executive Nurse Director	N/A	As per Patient Rights Act & Patient Rights Directions.
5.4.5	Monitoring & reporting of patient complaints (including key themes, trends & learning)	NHS Board	Clinical & Care Governance Committee	N/A	As per Patient Rights Act & Patient Rights Directions. Executive Lead: Executive Nurse Director
5.4.6	Monitoring of compliance & adherence to national standards relating to Healthcare Acquired Infection (HAI)	Clinical & Care Governance Committee	Director of Public Health	N/A	Also forms part of routine performance monitoring reporting to the NHS Board.
5.4.7	Monitoring of compliance & adherence to national standards relating to decontamination	Director of Facilities	N/A	N/A	Also forms part of routine performance monitoring reporting to the NHS Board.
5.4.8	Development of policies & procedures in relation to the safe &	Director of Pharmacy	N/A	N/A	The Director of Pharmacy is the NHS Board's Controlled Drugs Accountable Officer as per the Controlled Drugs

	secure management of Controlled Drugs				(Supervision of Management and Use) Regulations 2013. See 5.5.11.
STAFF GOVERNANCE					
5.4.9	Implementation of the NHS Scotland staff governance framework & associated action plan	Director of People	N/A	N/A	Monitored via the Area Partnership Forum & the Staff Governance Committee.
5.4.10	Compliance with equality legislation	NHS Board	Director of People	N/A	See NHS Forth Valley Equality & Inclusion Strategy 2021-25
5.4.11	Approval of a Workforce Strategy (& supporting recruitment & retention policies)	NHS Board	Staff Governance Committee	Within available resources	Engagement required with Area Partnership Forum. Workforce strategy should align with the Delivery Plan & the Financial Plan.
5.4.12	Monitoring & operation of whistleblowing policy	Staff Governance Committee	Area Partnership Forum	N/A	Executive Lead: Executive Nurse Director
5.4.13	Oversight of safe staffing legislation	Staff Governance Committee	Director of People	Within available resources	Clinical & Care Governance Committee
RISK MANAGEMENT					
5.4.14	Oversight of risk management framework	Audit & Risk Committee	Chief Executive	N/A	See NHS Forth Valley Risk Management Strategy 2022-25
5.4.15	Oversight of strategic risk register	Audit & Risk Committee	Director of Strategic Planning & Performance	N/A	Review of the Strategic Risk Register is a standing agenda items at the Audit & Risk Committee and NHS Board meetings.
5.4.16	Development of prescribing policies	Area Drug & Therapeutic Committee	Director of Pharmacy	N/A	Executive Lead: Medical Director
PLANNING					
5.4.17	Development & approval of a local population health & care strategy	NHS Board	Director of Public Health	As per approved financial plan	As per National Clinical Strategy & DL(2024)31 “a renewed approach to population based planning across NHS Scotland”.
5.4.18	Approval of Annual Delivery Plan	NHS Board	Director of Strategic Planning & Performance	As per approved financial plan	As per Scottish Government Annual Delivery Plan guidance (draft plans to be submitted in January with final plans in March).

5.4.19	Preparation & maintenance of a comprehensive Civil Contingency Plan	Director of Strategic Planning & Performance	Head of Strategic Planning	N/A	As per the Civil Contingencies Act 2004 & regulations. Executive Lead: Director of Public Health
5.4.20	Preparation & maintenance of a Business Continuity Plan	Director of Strategic Planning & Performance	Head of Strategic Planning	N/A	Oversight via Audit & Risk Committee. Executive Lead: Director of Public Health
5.4.21	Nominated representative in local Community Planning Partnerships	Director of Public Health	N/A	N/A	Clackmannanshire community planning partnership Falkirk community planning partnership Stirling community planning partnership
INFORMATION GOVERNANCE					
5.4.22	Oversight of information management systems & strategy, including monitoring delivery of the Digital & eHealth plan.	Strategic Planning, Performance & Resources Committee	Director of Digital	As per approved financial plan	As per national Digital Health & Care Strategy and local Health & Care in the digital age: a digital strategy for NHS Forth Valley 2023-2027 Executive Lead: Director of People. Clinical Lead: Medical Director.
5.4.23	Responsibility for Freedom of Information publication scheme & associated publication plan	Medical Director	Head of Information Governance	N/A	As per the Freedom of Information (Scotland) Act 2002 (FOISA). The publication scheme requires approval by the Information Commissioner's Office (ICO). See model publication scheme.
5.4.24	Responsibility for corporate records management plan	Medical Director	Head of Information Governance	N/A	In conjunction with the Senior Information Risk Owner (SIRO).
PERFORMANCE MANAGEMENT					
5.4.25	Approval of performance management framework	Strategic Planning, Performance & Resources Committee	Director of Strategic Planning & Performance	N/A	NHS Forth Valley performance management framework
5.4.26	Oversight of performance & performance reporting arrangements.	Strategic Planning, Performance & Resources Committee	Director of Strategic Planning & Performance	Within approved budget	Performance is a standing agenda item at every Strategic Planning, Performance & Resources Committee and NHS Board meeting.

5.5 Delegated Powers Arising from Other Operating Activities and Statutory Requirements:

Ref	Area of responsibility	Delegated to	Further delegation permitted	Limits applying £	Comments
Delegated powers arising from other operating activities & statutory requirements					
COMMUNICATION					
5.5.1	Develop & maintain a public facing access policy	Chief Executive	Head of Communications	N/A	In line with the NHS Scotland national access policy which sets out how NHS Boards should ensure equitable, safe, clinically effective and efficient access to services for their patients.
5.5.2	Develop & maintain a Communications Framework	Chief Executive	Head of Communications	N/A	See NHS Forth Valley Communications Framework 2023 - 2028
PATIENTS PRIVATE FUNDS & PROPERTY					
5.5.3	Develop detailed procedures for the safe custody & management of patients' funds & property	Director of Finance	Deputy Director of Finance	N/A	See Financial Operating Procedure (FOP) 17.
5.5.4	Approval of Patient Funds Annual Accounts	NHS Board	N/A	N/A	Patients fund accounts are subject to external audit.
STATUTORY REQUIREMENTS					
5.5.5	Nominated Lead Executive Director for Person Centred Care & engagement	Executive Nurse Director	N/A	N/A	
5.5.6	Responsibility for all aspects of Health & Safety	Chief Executive	Director of Facilities & Director of People	N/A	The Staff Governance Committee will consider the overall approach to staff safety & performance in relation to the precision of a safe and healthy working environment.
5.5.7	Implementation of Adult & Child support & protection policy	Chief Executive	Executive Nurse Director/ Directors of Health & Social Care	N/A	Adult Support & Protection (Scotland) Act 2007 national-guidance-child-protection-scotland-2021-updated-2023.pdf
5.5.8	Caldicott Guardian	Medical Director	Director of Public Health	N/A	This is an advisory role aligned with the Caldicott principles
5.5.9	Senior Information Risk Owner (SIRO)	Director of Finance	Chief Executive	N/A	The SIRO is the overall owner of information risk within the organisation & acts as the focal point for information

					risk management in the organisation including resolution of any pan-organisation or other escalated risk issues raised by Information Asset Owners. The SIRO will provide written advice to the Chief Executive on the content of the Governance Statement regarding information risk.
5.5.10	Nominated Fraud Liaison Officer	Regional Internal Audit Manager	Director of Finance	N/A	The role and responsibilities of the Fraud Liaison Officer is set out within Annex B of CEL11(2013) "Strategy to Combat Financial Crime in NHS Scotland".
5.5.11	Controlled Drugs Accountable Officer (CDAO)	Director of Pharmacy	N/A	N/A	As per the Controlled Drugs (Supervision of Management and Use) Regulations 2013.
OTHER					
5.5.11	Compliance with guidelines on chaplaincy & spiritual care	Executive Nurse Director	N/A	N/A	See national NHS Scotland Spiritual Care and Chaplaincy guidance.

SECTION F

Standing Financial Instructions

SECTION 1: INTRODUCTION

1.1 GENERAL

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the financial directions issued by the Scottish Government Health and Social Care Directorate under the provisions contained in regulation 4 of the National Health Service (Financial Provisions) (Scotland) Regulations 1974, together with the subsequent guidance and requirements contained in NHS Circular No.1974 (GEN) 88 and NHS Circular MEL (1194) 80, and shall have the effect as if incorporated in the Standing Orders of Forth Valley NHS Board. The purpose of the SFIs is to provide a sound basis for the control of Forth Valley NHS Board's financial affairs and for the regulation of the conduct of Forth Valley NHS Board, its directors, officers, and agents in relation to all financial matters in line with the Health Boards (Membership and Procedure) Regulations 2001. NHS Forth Valley is the common name of Forth Valley NHS Board. The Board's formal, legal title remains Forth Valley NHS Board and it will be identified as such in certain legal and financial documents.

1.1.2 These SFIs outline the financial responsibilities, policies, and procedures to be adopted by Forth Valley NHS Board. They are designed to ensure that Forth Valley NHS Board financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency, and effectiveness. The SFIs do not provide detailed procedural advice and should therefore be read in conjunction with all relevant Financial Operating Procedures, departmental instructions and the Scheme of Delegation adopted by the Board.

1.1.3 All Board members, officials, staff and agents of Forth Valley NHS Board shall observe these SFIs. The Chief Executive, Directors and Members of the Executive Leadership Team shall be responsible for ensuring that all staff and agents of the Board are aware of, and adhere to, the SFIs.

1.1.4 Statutory Instrument (1974) No.468 requires Directors of Finance to design, implement and supervise systems of financial control and NHS circular 1974 (GEN) 88 requires the Director of Finance to:

(a) approve the financial systems.
(b) approve the duties of officers operating these systems.
(c) maintain a written description of such approved financial systems, including a list of specific duties.

1.1.5 Should any difficulties arise regarding the interpretation or application of any aspect of the SFI's then the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the Provisions of the Board's Standing Orders.

1.1.6 Failure to comply with SFIs is a disciplinary matter, which could result in dismissal.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in directions made under the Acts, shall have the same meaning in these instructions; and:

(a) "Board" means the Board of Forth Valley NHS Board or such Committee of the Board to which powers have been delegated.
(b) "Budget" means an allocation of resources, expressed in financial terms, proposed by Forth Valley NHS Board for the purpose of carrying out, for a specific period, any, or all of the functions of Forth Valley NHS Board.
(c) "Chief Executive" means the chief officer of Forth Valley NHS Board and who is directly accountable to the Board.
(d) "Director of Finance" means the chief financial officer of Forth Valley NHS Board.
(e) "Budget Holder" means the director or officer of Forth Valley NHS Board who has the delegated authority to manage finances (income and expenditure) for a specific operational area of Forth Valley NHS Board.
(f) "Legal Adviser" means the properly qualified person appointed by Forth Valley NHS Board to provide legal advice.

1.2.2 Wherever the title Chief Executive, Director of Board, or other nominated officer is used in these instructions, it shall be deemed to include such other officers and agents who have been duly authorised to represent them.

1.2.3 References in these instructions to "officer" shall be deemed to include all employees of Forth Valley NHS Board, including nursing and medical staff, and consultants who practice upon Forth Valley NHS Board premises, as well as the staff of any agency contracted to Forth Valley NHS Board and/or performing financial functions on behalf of Forth Valley NHS Board.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board shall exercise financial supervision and control by:

(a) requiring the submission and approval of financial plans and budgets within approved allocations/overall income to a pre-determined timetable
(b) defining and approving essential features of financial arrangements in respect of important procedures and financial systems (including the need to obtain value for money)
(c) defining specific responsibilities placed on directors and officers as indicated in the Scheme of Delegation document

1.3.2 Within the SFIs it is acknowledged that the Chief Executive and Director of Finance shall have joint responsibility for ensuring that the Board meets its obligation to perform its functions within the financial resources available. The Chief Executive has overall responsibility for the Board's activities and is responsible to the Board for ensuring containment within the Board's Revenue Resource Limit, Capital Resource Limit and Cash Requirement Limit.

1.3.3 The Chief Executive is also the Accountable Officer for Forth Valley NHS Board as defined under the Public Finance and Accountability (Scotland) Act 2000 and is personally responsible to the Scottish Parliament. The specific responsibilities of the Chief Executive as Accountable Officer are set out in Section 2.

1.3.4 Forth Valley NHS Board shall delegate executive responsibility for the performance of its functions to the Chief Executive and the Senior Leadership Team (SLT). Members of the SLT will exercise financial supervision and control by requiring the submission and approval of financial plans within approved allocations, by defining and approving essential features of financial arrangements in respect of important procedures and financial systems, including the need to obtain value for money and by defining specific responsibilities placed on our officers.

1.3.5 So far as is possible, the Chief Executive and Director of Finance will delegate their detailed responsibilities but retain their overall accountability. The extent of delegation will be kept under review by the Board.

1.3.6 Without prejudice to any other functions of officers of Forth Valley NHS Board, the Director of Finance shall be responsible for:

(a) provision of financial advice to the Board and its officers
(b) setting the Board's accounting policies consistent with Scottish Government and Treasury guidance and generally accepted accounting practice
(c) supervising the implementation of the Board's financial strategies and for coordinating any corrective action necessary to further these strategies
(d) ensuring that sufficient records are maintained to show and explain Forth Valley NHS Board transactions, in order to disclose, with reasonable accuracy, the financial position of Forth Valley NHS Board at any time
(e) the design, implementation, and supervision of systems of financial control incorporating the principles of segregation of duties and internal checks
(f) the preparation and maintenance of such accounts, certificates, estimates, records, and reports as the Board may require for the purpose of carrying out its statutory duties and responsibilities

1.3.7 All directors and officers of Forth Valley NHS Board, severally and collectively, are responsible for:

(a) the security of Forth Valley NHS Board property
(b) avoiding loss
(c) exercising economy and efficiency and securing best value in the use of Forth Valley NHS Board resources; complying with the requirements of:

- Standing Orders (including the Scheme of Delegation)
- Standing Financial Instructions
- Financial Operating Procedures
- the NHS Scotland conduct policy and the Board's local business code of conduct policy.

1.3.8 The form in which financial records are kept and the manner in which duties are discharged by all directors and officers of Forth Valley NHS Board who carry out a financial function must be to the satisfaction of the Director of Finance and in line with

the Public Records Scotland Act 2011, data protection legislation (consisting primarily of the UK-GDPR and Data Protection Act 2018), the Freedom of Information (Scotland) Act 2002, and the Board's Information Governance policies and procedures.

1.3.9 Any contractor, agent or employee of a contractor who is empowered by Forth Valley NHS Board to commit Forth Valley NHS Board to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

SECTION 2: RESPONSIBILITIES OF HEALTH BOARD CHIEF EXECUTIVE AS ACCOUNTABLE OFFICER

2.1 INTRODUCTION

2.1.1 In accordance with part 2 section 15 of the Public Finance and Accountability (Scotland) Act 2000, the Principal Accounting Officer for the Scottish Government has designated the Chief Executive of Forth Valley NHS Board as Accountable Officer.

2.1.2 Accountable Officers must comply with the terms of annex 2 of the Scottish Public Finance Manual (SPFM), and any updates issued to the manual by the Principal Accountable Officer for the Scottish Government.

2.2 GENERAL RESPONSIBILITIES

2.2.1 The Accountable Officer is personally answerable to the Scottish Parliament for the propriety and regularity of the public finances for NHS Forth Valley. The Accountable Officer must ensure that Forth Valley NHS Board takes account of all relevant financial considerations, including any issues of propriety, regularity, or value for money, in considering policy proposals relating to expenditure, or income.

2.2.2 It is incumbent upon the Accountable Officer to combine their duties as Accountable Officer with their duty to the Forth Valley NHS Board, to whom they are responsible, and from whom they derive their authority. The Forth Valley NHS Board is in turn responsible to the Scottish Parliament in respect of its policies, actions, and conduct.

2.2.3 The Accountable Officer has a personal duty of signing the Annual Accounts of Forth Valley NHS Board and for their proper presentation as prescribed in legislation and/or in the relevant Accounts Direction issued by the Scottish Ministers. Consequently, they may also have the further duty of being a witness before the Audit Committee of the Scottish Parliament and be expected to deal with questions arising from the Accounts, or, more commonly, from reports made to Parliament by the Auditor General for Scotland.

2.2.4 The Accountable Officer must ensure that any arrangements for delegation promote good management, and that they are supported by the necessary staff with an appropriate balance of skills. This requires careful selection and development of staff and the sufficient provision of, or access to, specialist skills and services. The Accountable Officer must ensure that staff are as conscientious in their approach to costs not borne directly by NHS Forth Valley (such as costs incurred by other public bodies, or financing costs, e.g., relating to banking and cash flow) as they would be where such costs directly borne.

2.3 SPECIFIC RESPONSIBILITES

2.3.1 The Accountable Officer must:

(a) ensure that from the outset, proper financial systems are in place and applied, and that procedures and controls are reviewed from time to time to ensure their continuing relevance and reliability, especially at times of major changes.

(b) sign the Annual Accounts and the associated governance statement, and in doing so accept personal responsibility for their proper presentation as prescribed in legislation and/or relevant Accounts Direction issued by Scottish Ministers.

(c) ensure that proper financial procedures and systems of internal control are followed and that accounting records are maintained in a form suited to the requirements of management as well as in the form prescribed for published Accounts as per the NHS Scotland Annual Accounts Manual.

(d) ensure that the public funds for which the Accountable Officer is responsible are properly managed and safeguarded, with independent and effective checks of cash balances in the hands of any official.

(e) ensure that the assets for which the Accountable Officer is responsible, such as land, buildings, or other property, including stores and equipment, are controlled, and safeguarded with similar care, and with checks as appropriate.

(f) ensure that, in the consideration of policy proposals relating to expenditure, or income, for which the Accountable Officer has responsibility, all relevant financial considerations, including any issues of propriety, regularity or value for money, are considered, and where necessary brought to the attention of the Board.

(g) ensure that any delegation of authority is accompanied by clear lines of control and accountability, together with reporting arrangements.

(h) ensure that any procurement activity is conducted in accordance with the requirements in the procurement section of the SPFM and all relevant procurement legislation and regulations as they apply to the NHS in Scotland.

(i) ensure that effective management systems appropriate for the achievement of the organisation’s objectives, including financial monitoring and control systems have been put in place.

(j) ensure that risks, whether to achievement of business objectives, regularity, propriety, or value for money, are identified, that their significance is assessed and that systems appropriate to the risks are in place in all areas to manage them.

(k) ensure that arrangements have been made to secure best value as set out in the SPFM.

(l) ensure that managers at all levels have a clear view of their objectives and the means to assess and measure outputs or performance in relation to these objectives.

(m) ensure managers at all levels are assigned well defined responsibilities for making the best use of resources (both those assumed by their own commands and any made available to third parties) including a critical scrutiny of outputs, outcomes, value for money and compliance with any conditions of funding awards/grants.

(n) ensure that managers at all levels have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

(o) ensure that the common seal of the Board is held securely by the Corporate Business Manager who shall be responsible for its safe custody and for recording its use.

(p) Ensure that any document or proceeding requiring authentication by the Board by affixation of its common seal shall be subscribed by the Chief Executive and Director of Finance.

(q) to ensure where a document requires for the purpose of any enactment or rule of law relating to authentication of documents under the Law of Scotland, or otherwise requires to be authenticated on behalf of the NHS Board, it shall be signed by an Executive Director of the NHS Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the provisions of the Requirements of Writing (Scotland) Act 1995. Before authenticating any document the person authenticating the document shall satisfy themselves that all necessary approvals in terms of the NHS Board procedures have been received. A document executed by the NHS Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.

2.4 REGULARITY AND PROPRIETY OF EXPENDITURE

2.4.1 The Accountable Officer has a particular responsibility for ensuring compliance with parliamentary requirements in the control of expenditure. A fundamental requirement is that funds should be applied only to the extent and for the purposes authorised by Parliament in Budget Acts (or otherwise authorised by section 65 of the Scotland Act 1998).

2.4.2 Parliament's attention must be drawn to losses or special payments by appropriate notation of the Board's Accounts. In the case of expenditure approved under the Budget Act, any payments must be within the scope and amount specified in that Act. In cases not covered by the Budget Act, e.g. in connection with a service not contemplated when the Budget Bill was presented; the Accountable Officer must ensure that the Scottish Government Health and Social Care Directorate is informed in order that appropriate advice can be given, and if necessary parliamentary procedures followed.

2.4.3 The Accountable Officer will advise the Forth Valley NHS Board, as appropriate, on all matters of financial probity and regularity, on prudent and economical administration; efficiency and effectiveness and, in particular, will provide assurance that expenditure by NHS Forth Valley complies with Parliamentary requirements, relevant legislation and relevant guidance issued by the Scottish Ministers in particular the SPFM. In meeting these requirements, the Accountable Officer must:

- Not exceed the revenue resource limit (RRL) (taking one year with another).
- Draw the attention of Parliament to losses or payments by appropriate notation of the statutory accounts.
- Obtain approval from the Scottish Government Health and Social Care Directorate for any expenditure which exceeds the Board's RRL or is not covered by standing delegated authorities e.g. losses and special payments in excess of specific delegated limits or expenditure which is considered novel, contentious or repercussive.
- Ensure that all items of expenditure, including payments to staff, fall within the legal powers of the Forth Valley NHS Board, are exercised responsibly and with due regard for probity and value for money.
- Comply with guidance issued by the Scottish Government Health and Social Care Directorate on classes of payments and authorise personally, such payments as termination payments to other Chief Officers.

SECTION 3: ALLOCATIONS, BUSINESS PLANNING, BUDGETS AND BUDGETARY CONTROL

3.1 GENERAL

3.1.1 The Board is required by statutory provisions made under Section 85 of the National Health Service (Scotland) Act (1978), as amended by the Health Services Act 1980, to perform its functions within the total funds allocated by the Scottish Ministers. All plans and financial approval systems shall be designed to meet this obligation.

3.2 ALLOCATIONS

3.2.1 The Director of Finance of the Board will review, as a minimum annually, the bases and assumptions used for distributing allocations to ensure such allocations are fair, realistic, and secure the Board's entitlement to funds.

3.3 BUSINESS PLANNING AND BUDGETS

3.3.1 The Chief Executive will prepare, and submit to the board for approval, an Annual Delivery Plan. The delivery plan will reflect financial targets and forecast limits of available resources and will describe the planning assumptions and the necessary changes in workload, delivery of services or resources required to achieve the plan.

3.3.2 The Director of Finance shall, on behalf of the Chief Executive, prepare and submit to the Board, an annual financial plan. The financial plan will incorporate both revenue and capital expenditure within the limits of available funds as determined by the notified allocations and will align to the annual delivery plan. The financial plan will be submitted to the Board for approval in March, in advance of the financial year to which it relates.

3.3.3 The Director of Finance shall ensure that the delivery plan and the financial plan are reconcilable to budgets and reflect t h e outcome of discussions and consultation with the ELT, the Performance and Resources Committee and other stakeholders. As a consequence, the Director of Finance shall have right of access to all budget holders on all and any budgetary related matters.

3.4 BUDGETARY CONTROL

3.4.1 The Board shall delegate the management of the Financial Plan to the Chief Executive. The Chief Executive within limits approved by the Board, can delegate responsibility for a budget or part of a budget to individual Senior Managers. The terms of delegation shall include, in writing, a clear definition of individual responsibilities for control of expenditure, exercise of virement, achievement of performance levels and the provision of regular reports on the discharge of these delegated functions. The delivery of this delegation shall be included within the performance review of appropriate officers.

3.4.2 In performance of their duties:

(a) The Chief Executive will not exceed the budgetary or virement limits or exclusions set by the Board or by the Scottish Government Health and Social Care Directorate.

(b) Senior Managers will not exceed the budgetary or virement limits set by the Board and Chief Executive.

(c) The Chief Executive may exercise virement or vary the budgetary limit of a Senior Manager within the Chief Executives own budgetary limit.

3.4.3 The Board shall approve and review annually a Scheme of Delegation that will form part of the Standing Orders of the Board. The Scheme of Delegation shall specify: -

(a) areas of responsibility

(b) nominated officers

(c) financial value

(d) virement levels

3.4.4 Expenditure for which no provision has been made in approved plans and budgets and outwith delegated virement limits may only be incurred after authorisation by the Chief Executive or the Director of Finance acting on their behalf, or the NHS Board dependent on the nature and level of expenditure. There shall be a financial limit of £500,000 in respect of the delegated authority of the Chief Executive on a non-recurring basis (no individual item shall exceed £100,000). The Director of Finance shall have authority within the Chief Executive's limit of £250,000.

3.4.5 The Director of Finance, on behalf of the Chief Executive, shall monitor the financial performance against the plan, the use of delegated budgets to ensure that financial control is maintained, and that the Board's plans and policies are implemented.

3.4.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget-holders to help them to manage successfully.

3.4.7 The Director of Finance shall ensure that:

(a) the system of internal financial controls is sufficient and adequate to ensure the achievement of objectives and compliance with standards and regulations.

(b) adequate statistical and financial systems are in place to monitor and control all agreements for patients' services and facilitate the compilation of estimates, forecasts and investigations as may be required.

(c) reports provide all financial, statistical, and other relevant information as necessary for the compilation of estimates and forecasts.

(d) the Chief Executive and the Board are informed of the financial consequences of changes in policy, pay awards and other events and trends affecting budgets or projections and shall advise on the financial and economic aspects of future plans and projects.

(e) the issue of timely, accurate and comprehensible advice, and monthly financial reports to each budget holder, covering the areas for which they are responsible.

(f) The provision of financial information as per the requirements of extant Integration Schemes to support Chief Finance Officers in their role as section 95 Officers for the Integration Joint Board.

3.4.8 The Director of Finance shall provide the Board with regular financial reports including, but not limited to, the following details: -

- analysis of all income and expenditure to date and a forecast year-end position;
- progress in delivering agreed cost improvement plans & efficiency savings;
- movements in working capital;
- capital project spend and projected outturn against plan;
- explanation of significant variances from plan plus corrective action if appropriate, including an assessment as to whether such actions are sufficient to correct the situation;
- monitoring of management action to correct variances; cash spending to date and forecast year-end position;
- report on budgetary transfers and virement.

SECTION 4: HEALTH AND SOCIAL CARE INTEGRATION

4.1 GENERAL

4.1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 established the framework for the integration of adult health and social care services in Scotland. Two Integration Joint Boards (IJBs) have been established in Forth Valley under the body corporate arrangement. The approved Integration Schemes set out the detail of the integration arrangement, including those functions delegated by NHS Forth Valley to the IJBs.

4.2 FINANCIAL ARRANGEMENTS

4.2.1 Each partner will agree an annual payment to the IJB in advance of financial year to which it relates as per the requirements of the extant Integration Schemes. The value of the annual payment will be informed by Scottish Government policy and the preparation of a business case by each IJB. The business case will summarise the funding requirements and financial planning assumptions of the IJB and will form the basis of initial negotiations with the NHS Board and Local Authority as to level of payment/funding contributions for the forthcoming financial year.

4.2.2 In subsequent financial years the NHS Board will evaluate the case for the Integrated Budget against its other priorities and will agree its contributions accordingly. The business case put forward by the IJB will be evidenced based and will detail assumptions made.

4.2.3 Following agreement of the payment to the IJB by the NHS Board and Local Authority, the IJB Chief Officer and Chief Finance Officer will prepare a financial plan to support achievement of the IJB's approved Strategic Plan. To deliver the strategic plan, the IJB will commission services from the NHS Board and Local Authority by issuing a Direction.

4.2.4 In line with the provisions of sections 26 to 28 of the Public Bodies (Joint Working) (Scotland) Act 2014, Directions are the mechanism by which the IJB's strategic commissioning plan is actioned and they represent the legal basis for the NHS Board and Local Authority to deliver services which are under the control of the IJB. The Direction from the IJB must set out how services are to be delivered and funded (including details of the funding source, distinguishing between sums Set Aside or a payment from the IJB to the NHS Board via the integrated budget).

4.2.5 Following receipt of a Direction from the IJB (assuming paragraph 4.2.6 below does not apply), the NHS board will adjust the relevant Set Aside or Health and Social Care Partnership (HSCP) operational or universal budget and will inform budget holders accordingly. HSCP budget holders are responsible for ensuring all transactions processed by the NHS Board comply with these SFIs and any associated detailed procedural NHS guidance deemed relevant to the transaction.

4.2.6 If the NHS Board does not believe the direction can be achieved for the payment being offered, then it shall notify the IJB as soon as possible that additional funding would be necessary to comply with the direction.

4.3 DELEGATED AUTHORITY

4.3.1 Where a manager has delegated authority for integrated health and social care expenditure, they must ensure the VAT treatment is in line with the guidance issued by the Integrated Resource Advisory Group and HMRC. If in doubt they should seek advice from the Director of Finance and/or IJB Chief Finance Officer.

4.3.2 Where a Local Authority employee has been given delegated authority for an integrated budget that includes NHS transactions, a signed declaration confirming that they have received and will comply with these SFIs is required. This should also be signed by the IJB Chief Officer, who will further undertake to pursue any breaches of the NHS SFIs through the Local Authority line management structure if required.

4.3.3 The Integration Scheme includes further detailed guidance on the financial governance and financial management arrangements for IJBs.

SECTION 5: COMMISSIONING OF HEALTHCARE

5.1 FINANCIAL TARGETS

5.1.1 The Scottish Government sets 3 budget limits at a Health Board level on an annual basis. These limits are:

(a) Revenue Resource Limit: a resource budget for ongoing operations;
(b) Capital Resource Limit: a resource budget for net capital investment;
(c) Cash requirement: a financing requirement to fund the cash consequences of the ongoing operations and net capital investment.

5.1.2 Health Boards are required to contain their net expenditure within these limits and will report on any variation from the limits as set.

5.1.3 The Director of Finance shall be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Board to fulfil its statutory responsibility while achieving its financial targets.

5.2 GENERAL - HEALTH NEEDS ASSESSMENT

5.2.1 The Director of Public Health, on behalf of the Chief Executive, is responsible for the production of Health Needs Assessments and for the monitoring of Health Status and overall population health.

5.2.2 The Health Needs Assessment Reports incorporate historical and projected financial information. The Director of Finance is responsible for the provision of historical financial details and for the financial impact/implication of each Needs Assessment.

5.3 GENERAL - HEALTH PLANNING

5.3.1 The Chief Executive is responsible for the production of the Corporate Plan (Healthcare Strategy). The Corporate Plan will be informed amongst others by

(a) plans arising from Health Needs Assessments

(b) socio-demographic trends

(c) public consultation

(d) resource availability

(e) Business unit pressures

5.3.2 Planning groups may be established to prepare health strategies or develop plans for individual care groups or non-delegated service areas that are not part of integrated health and social care services. The Director of Finance has responsibility for ensuring that where appropriate the remit of such groups outlines the financial parameters within which the group may operate. On occasion these groups may also

cover non-delegated Local Authority services. In this instance the parameters should be agreed with the appropriate individuals within Local Authorities.

5.3.3 The Director of Finance is responsible for the provision of financial advice and plans in respect of the affordability of the Corporate Plan.

5.4 PRIMARY HEALTH CARE

5.4.1 Primary Health Care Services include:

(a) all Family Health Services

(b) Staff employed by NHS Forth Valley that are attached to specific GP Practices eg District Nursing

(c) General Medical Services (GMS) IT

(d) Services provided as part of the Primary Care Improvement Plan

5.4.2 Primary Healthcare Services fall within the scope of Integration Authorities and are hosted by Falkirk IJB. Resources are allocated from both IJBs to the NHS Board via Direction in line with IJB Strategic Commissioning Plans. Any variations proposed to budgets must be approved by the IJB Chief Finance Officer.

5.5 COMMUNITY SERVICES

5.5.1 Community Services include:

(a) mental health (inclusive of elderly, frail elderly, long-stay, and community)

(b) learning disability

(c) palliative hospice care

(d) community health services

(e) drugs and alcohol

(f) healthcare in prisons

5.5.2 The vast majority of local Community Health Care Services fall within the scope of integration authorities and are operationally managed by IJB Chief Officers through their role as Director of the Health and Social Partnership. Any variations proposed to budgets relating to IJB delegated services must be approved by the relevant IJB Chief Finance Officer.

For community services that are not delegated to IJBs , resources are transferred on a monthly basis in accordance with the annual financial plan and any subsequent agreed variations. Any approved budget adjustments are processed through the Service Agreement Variation (SAV) process in year. Such variations must be approved by the Director of Finance of Forth Valley NHS Board.

5.5.3 NHS Boards outwith the Forth Valley area may also provide Community services to local residents. In such instances service level agreements will be prepared. Resources are transferred on a monthly basis in accordance with the annual financial plan and any subsequent agreed variations. Such variations must be signed by both the Director of Finance of the Forth Valley NHS Board and the Director of Finance of the appropriate Health Board.

5.6 INPATIENT AND OTHER HOSPITAL BASED SERVICES

5.6.1 These include:

(a) Emergency and urgent care

(b) Acute inpatients and Community Hospital beds

(c) Ambulatory Care and Day Surgery

(d) Outpatient Services

(e) Cancer Services

(f) Allied Health Professionals

(g) Diagnostic Services

(h) Women and Children Services

5.6.2 Inpatient and other hospital-based services are operationally managed by the Director of Acute Services. However, an element of this budget is “set aside” by NHS Forth Valley to be included as part of the total resources within the scope of the IJB Strategic Plans as per the extant Integration Schemes.

5.6.3 Set aside, also referred to as Large Hospital Services, is defined as services which are carried out in a hospital setting and provided for the areas of two or more Local Authorities. They typically include services relating to emergency and unscheduled care and whilst operational management and financial risk for the Set Aside budgets remains with NHS Forth Valley, the IJBs have a strategic planning role in relation to these services.

5.6.4 Resources for Inpatient and other hospital-based services which are categorised as set aside are allocated from the Integration Authority via direction in line with their Strategic Commissioning Plans. Any variations proposed to set aside budgets must be approved by the Director of Finance of Forth Valley NHS Board and the relevant IJB Chief Finance Officer.

5.6.5 Resources in respect of Inpatient and other hospital based services that are not part of set aside are operationally managed by the Director of Acute Services. Resources for these service areas are transferred on a monthly basis in accordance with the annual financial plan and any subsequent agreed variations. Any approved budget adjustments are processed through the Service Agreement Variation (SAV) process in year. Such variations must be approved by the Director of Finance of Forth Valley NHS Board.

5.6.6 NHS Boards outwith the Forth Valley area may also provide these services to local residents. In such instances service agreements will be prepared. Resources are transferred on a monthly basis in accordance with the annual financial plan and any subsequent agreed variations. Such variations must be signed by both the Director of Finance of the Forth Valley NHS Board and the Director of Finance of the appropriate Health Board.

SECTION 6: CASH AND BANKING

6.1 INTRODUCTION

6.1.1 The Director of Finance is responsible for managing Forth Valley NHS Board's banking arrangements and for advising Forth Valley NHS Board on the provision of banking services and the operation of bank accounts. This advice will take into account such guidance and directions as may be issued by the Scottish Government Health and Social Care Directorate.

6.2 CASH HANDLING

6.2.1 The Director of Finance is responsible for:

(a) Ensuring a process is in place for the timely banking of cash receipts;
(b) Preparing procedures on the use of petty case, and
(c) Ensuring controls are in place for secure handling of cash.

6.2.2 Staff, on appointment, shall be informed in writing by the appropriate departmental or Senior Manager, of their responsibilities and duties for the collection, handling or disbursement of cash, cheques etc and must familiarise themselves with the relevant Financial Operating Procedure.

6.3 SECURITY

6.3.1 All receipt books, tickets, agreement forms or other means of officially acknowledging or recording amounts received or receivable shall be in a form approved by the Director of Finance. Such stationery shall be ordered and controlled by the Director of Finance and subject to the same precautions as are applied to cash.

6.3.2 All employees with an official duty to collect or hold cash must have access to a secure safe and lockable cash box. Safes will normally be accessible to authorised individuals by combination code. For key access safes and cash boxes spare keys must be held securely and recorded on a register, with only authorised staff allowed to gain access. Any loss of keys must be reported immediately to the Finance Department.

6.3.3 All cash, cheques, postal orders, and other forms of payment received by someone other than the cashier shall be entered immediately in an approved form of register. The remittances must be passed to the cashier and a signature obtained to evidence the handover.

6.3.4 The opening of coin operated machines (including telephones) and the counting and recording of takings shall be undertaken by two officers together, at frequent intervals,

and the coin box keys shall be held by a nominated officer. A reconciliation of monies collected should be carried out.

6.3.5 The Director of Finance shall prescribe the system for the transporting of cash and uncrossed pre-signed cheques and shall approve, where appropriate, the use of the services of a specialist security firm.

6.3.6 Official money must not, under any circumstances, be used to cash private cheques.

6.3.7 All cheques, postal orders, cash etc. shall be promptly banked. Disbursements must not be made from cash received except under arrangements approved by the Director of Finance.

6.3.8 Those with access to safes must not accept unofficial funds for depositing in their safes.

6.3.9 During the absence (e.g. due to annual leave) of the individual responsible for the safe and cash box, the employee who acts in their place shall be subject to the same controls as the normal safekeeper. Handover of the safe and/or cash box contents must be recorded and signed by both individuals upon the transfer of responsibilities. The signed document must be retained for audit purposes.

6.3.10 Cheque books will be controlled by officers approved by the Director of Finance and are subject to the same security precautions as are applied to cash. New books will be ordered as required via online banking by approved officers and must be stored in a secure safe.

6.3.11 Any loss or shortfall of cash, cheques, or other items, regardless of how it occurred, shall be reported immediately in accordance with the agreed procedure for reporting losses. (See Section 12 on Condemnations, Losses and Special Payments).

6.4 BANK ACCOUNTS

6.4.1 The Director of Finance is responsible for:

(a) Establishing exchequer bank accounts as directed by Scottish Government Health and Social Care Directorate;
(b) establishing separate bank accounts for Forth Valley NHS Board non exchequer funds;
(c) ensuring funds are drawn down from Scottish Government for approved expenditure but that excess funds are not drawn in advance of need;
(d) ensuring payments made from accounts do not exceed the amount credited to the account except where arrangements have been made;
(e) reporting to the Board all arrangements made with Forth Valley NHS Board bankers for accounts to be overdrawn, and
(f) The opening and operation of Project Bank Accounts when required for construction contracts in line with Scottish Government guidance.

6.4.2 Bank accounts will be operated in accordance with the HM Treasury Government Banking Services (GBS) contract, the Scottish Government Banking Services Framework for commercial accounts, and guidance in the Scottish Public Finance Manual.

6.4.3 All funds shall be held in accounts in the name of Forth Valley NHS Board. No officer other than the Director of Finance plus one other approved signatory shall open or close any bank account in the name of Forth Valley NHS Board.

6.4.4 The Director of Finance will advise the Bankers in writing of the conditions under which each account shall be operated.

6.5 BANKING PROCEDURES

6.5.1 The Director of Finance shall prepare procedural instructions on the operation of accounts. These instructions must include:

(a) the conditions under which each account is to be operated;

(b) ensuring that funds held in commercial accounts are kept to a minimum and do not exceed £50,000 in total, with excess funds being transferred to the GBS account;

(c) those authorised to sign cheques or other payments on Forth Valley NHS Board accounts, and

(d) the required controls for online banking.

6.5.2 The Director of Finance shall ensure appropriate arrangements and controls are in place for debit/credit card transactions.

6.5.3 The Accounting Services Manager shall advise the bankers of the officers authorised to release money from or make electronic payment from each bank account.

6.5.4 The Accounting Services Manager shall notify the bankers promptly of the cancellation of any authorisation to draw on Forth Valley NHS Board accounts

6.5.5 Where an agreement is entered into with a Health Board or other body for payment to be made on behalf of Forth Valley NHS Board from bank accounts maintained in the name of that Health Board or other body, or by electronic funds transfer via the Bankers' Automated Clearing System (BACS), the Director of Finance shall ensure that satisfactory security regulations of the Health Board or other body relating to any such accounts exist and are observed.

SECTION 7: CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

7.1 CAPITAL INVESTMENT

7.1.1 The overall control of all capital investment and fixed assets shall be the responsibility of the Chief Executive, as advised by the Director of Finance.

7.1.2 Whilst the Board reserves decision making with regard to the medium term Capital Plan and the Annual Capital Plan, the Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital investment priorities and the effect of each proposal on the Board Health Strategy and Annual Delivery Plan in accordance with the guidance contained in the Scottish Capital Investment Manual (SCIM).

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost.

(c) will ensure that capital investment is not undertaken without confirmation of the availability of resources to finance all revenue consequences.

7.1.3 The Chief Executive will also ensure that, for every capital expenditure proposal:

(a) where required, a business case is prepared setting out an option appraisal of potential benefits compared with known costs to determine the option with the most favourable ratio of benefits to costs in accordance with the guidance contained in the Scottish Capital Investment Manual (SCIM).

(b) the Director of Finance has certified professionally to the costs and revenue consequences.

(c) appropriate project management and control arrangements are set in place.

7.1.4 On approval of a capital investment scheme in accordance with the Scheme of Delegation, the Director of Finance shall issue written communication to the manager responsible for the capital investment project confirming the following**:**

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) authority to accept a successful tender.

7.1.5 The Director of Finance shall ensure that procedures are in place for the regular reporting of actual expenditure against authorisation of capital expenditure.

7.1.6 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the Scottish Capital Investment Manual (SCIM).

7.1.7 The Chief Executive will issue a scheme of delegation for capital investment management which will be in accordance with:

(a) SCIM guidance

(b) Forth Valley NHS Board Standing Orders

(c) the schedule of financial limits

7.1.8 Competitive tendering processes as per Section 8 must be followed with the exception being when the supply is proposed under special arrangements negotiated by the Scottish Government in which event the said special arrangements must be complied with. This is applicable to processes under the auspices of nationally approved procurement programmes, including Frameworks Scotland and Hub Company, where the formal tendering process has been deemed to have been completed in arriving at the principal supply chain partners.

7.1.9 The Director of Finance will issue procedures governing the financial management of capital investment projects, including variations to contract and valuation for accounting purposes.

7.2 PRIVATELY FINANCED INFRASTRUCTURE INVESTMENT

7.2.1 When Forth Valley NHS Board proposes to use finance, which is to be provided other than through NHS Finances (as determined by its Capital Allocation), the following procedures shall apply:

(a) the Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;

(b) where the sum involved exceeds the limits of approval delegated to the Board, a business case must be prepared, and approved by the Board;

(c) the Business case must then be referred to the Scottish Government Health and Social Care Directorate for approval.

7.3 FIXED ASSET REGISTERS

7.3.1 The Chief Executive who has overall control of fixed assets will delegate responsibility for ensuring the maintenance of registers of assets and for prescribing the form and content of any register and the method of updating.

7.3.2 The minimum data set to be held within these registers shall be as specified in the NHS Scotland Capital Accounting Manual as issued by the Scottish Government Health and Social Care Directorate.

7.3.3 A fixed asset control procedure shall be approved by the Director of Finance. This procedure shall make provision for:

(a) recording the managerial responsibility for each asset

(b) identification of additions and disposals

(c) physical security of assets

(d) periodic verification of the existence of condition of and title to assets

7.3.4 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices, and other documentary evidence in respect of purchases from third parties

(b) stores requisitions and wages records for own materials and labour including appropriate overheads

(c) lease agreements in respect of assets held under a finance lease and capitalised

7.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

7.3.6 The value of each asset shall be indexed to current values in accordance with the methods specified in the NHS Scotland Capital Accounting Manual as issued by the Scottish Government Health and Social Care Directorate.

7.3.7 The value of each asset shall be depreciated using methods and rates as specified in the NHS Scotland Capital Accounting Manual as issued by the Scottish Government Health and Social Care Directorate.

7.3.8 Registers shall also be maintained by responsible nominated officers and receipts retained for:

(a) equipment on loan; and
(b) all contents of furnished lettings.

7.3.9 On the closure of any facility, a check shall be carried out and a responsible officer will certify an inventory of items held pending eventual disposal.

7.3.10 The Director of Finance shall approve a procedure for the calculation and payment of capital charges as specified in the NHS Scotland Capital Accounting Manual issued by the Scottish Government Health and Social Care Directorate.

7.4 SECURITY OF ASSETS

7.4.1 The Chief Executive is responsible for the overall control of the fixed assets of Forth Valley NHS Board, but all staff have a responsibility for the security of property of the Board. It shall be the responsibility of senior staff in all disciplines to apply appropriate routine security practices in relation to NHS property. Persistent breach of agreed security practices should be reported to the Chief Executive.

7.4.2 Wherever practicable, items of equipment shall be indelibly marked as Forth Valley NHS Board property.

7.4.3 The Director of Finance shall prepare procedural instructions on the security and checking and disposal of assets (including cash, cheques, and negotiable instruments, and also including donated assets). This procedure shall make provision for:

(a) recording managerial responsibility for each asset

(b) identification of additions and disposals

(c) identification of all repairs and maintenance expenses

(d) physical security of assets

(e) periodic verification of the existence of condition of, and title to, assets recorded

(f) identification and reporting of all costs associated with the retention of an asset

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments

7.4.4 Any damage to Forth Valley NHS Board premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors, Heads of Service or employees in accordance with the procedure for reporting losses.

SECTION 8: PURCHASING OF SUPPLIES AND SERVICES

8.1 DELEGATION OF AUTHORITY

8.1.1 The Forth Valley NHS Board will approve the total level of non-pay expenditure on an annual basis and the Director of Finance will determine the level of delegation to budget holders.

8.1.2 The Director of Finance will set out:

(a) the list of managers who are authorised to approve requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the process for authorisation above that level;

(c) the procedures to be adopted for the seeking of professional advice regarding the supply of goods and services.

8.1.3 All non-pay expenditure will be incurred within the limits of the non-pay budgets delegated to budget holders.

8.1.4 Section 21 sets out Standards of Business Conduct, which must be adhered to by members and officers of Forth Valley NHS Board.

8.2 SYSTEMS AND PROCEDURES FOR REQUISITIONING, ORDERING AND RECEIVING GOODS AND SERVICES

8.2.1 Supplies and services must be purchased through national contracts including framework agreements in accordance with CEL 05 (2012) where these are available. Only in exceptional circumstances and only with the authority of the Head of Procurement and the Director of Finance shall supplies and services available on contract be ordered outwith national contracts.

8.2.2 All formal contract arrangements must meet Information Governance requirements including appropriate patient confidentiality, information security, data protection and Freedom of Information requirements. The Head of Information Governance should be contacted for clarification in terms of use of standard wording and to resolve any queries that arise. The Caldicott Guardian has overall responsibility for Patient Information security.

8.2.3 Standard wording for inclusion within contracts has been prepared and the Head of Procurement should be contacted to confirm/advise on standard clauses. The Head of Procurement is responsible for compliance with this component of SFIs and ensuring compliance with CEL 05 (2012).

8.2.4 In line with the Procurement Reform (Scotland) Act 2014 competitive tenders for the supply of all goods and services not available to the Board through national or regional contracts will be invited by advertising on the Public Contracts Scotland website unless:

(a) the estimated value of the contract is (exclusive of VAT):

- less than £50,000 for building and engineering works
- less than £50,000 for other supplies
- less than £1,000 for disposals

(b) the supply or disposal is for goods or services of a special nature or character in respect of which it is not possible or desirable to obtain competitive tenders;

(c) in cases of emergency where it is not practicable or where the delay would result in further expense to the NHS Board. Such cases must be reported immediately to the Chief Executive.

8.2.5 A minimum of 3 written quotations shall be obtained from firms on approved lists (where possible) where the expenditure will be more than £5,000 but less than £50,000.

8.2.6 Where competitive tenders have been obtained, the lowest cost shall normally be accepted or, for disposals, the highest sales price. If other than the lowest (highest for disposals) is being recommended, the approval of the Chief Executive or the Director of Finance shall be obtained before acceptance and the reasons entered in the Register of Tenders.

8.2.7 Any Board Member or Officer concerned with a contract who has a pecuniary interest in that contract shall declare his interest in writing to the Chief Executive who shall maintain a register of all such declarations. The NHS Board Member or Officer concerned must withdraw from the decision-making process of the purchasing/contracting arrangements concerning that item. (See Section 21 – Standards of Business Conduct).

8.2.8 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for Forth Valley NHS Board. In so doing, the advice of Forth Valley NHS Board's sourcing adviser on supply shall be sought.

Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted before any order is placed.

8.2.9 The Director of Finance shall:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds must be incorporated in Forth Valley NHS Board Standing Financial Instructions and regularly reviewed; and

(b) prepare procedural instructions on the obtaining of goods, services and works, incorporating the thresholds set by the Board.

8.2.10 No order may be placed for any item, or items, for which there is no budget provision unless authorisation is provided by the Director of Finance on behalf of the Chief Executive.

8.2.11 All goods, services, or works must be ordered on an official order through the Board's electronic purchase to pay system ie the Professional Electronic Commerce Online System (PECOS) except for works and services executed in accordance with a contract and purchases from petty cash. Suppliers/Contractors shall be notified that they should not accept orders unless they are generated through PECOS.

8.2.12 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with European Commission (EC) and General Agreement on Tariffs and Trade (GATT) rules and comply with other such legislation relating to public procurement;

(c) where consultancy advice is being obtained, the procurement of such skills must be in accordance with guidance issued by the Scottish Government Health and Social Care Directorate;

(d) where eHealth and IT systems and/or software are being obtained, procurement of these items must be approved and processed through the Digital Directorate;

(e) in accordance with Section 21 – Standards of Business Conduct, no order is issued for any item, or items, to any firm which has made an offer of gifts, reward or benefit to Directors or employees, other than:

- isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars
- conventional hospitality, such as lunches in the course of working visits

(f) verbal orders are only issued in exceptional circumstances, in cases of emergency or urgent necessity, and only by an officer designated by the Chief Executive; these must be confirmed by an official order no later than the next working day, and clearly marked “Confirmation Order;”

(g) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(h) goods are not taken on trial or loan in circumstances that could commit Forth Valley NHS Board to a future uncompetitive purchase;

(i) changes to the list of directors/employees authorised to certify invoices are notified to the Accounting Services Manager;

(j) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

(k) petty cash records are maintained in a form as determined by the Director of Finance.

8.2.13 All tenders shall be addressed to the Chief Executive.

8.2.14 Official orders must:

(a) be consecutively numbered

(b) be in a form approved by the Director of Finance

(c) include such information concerning prices or costs as may be appropriate

(d) incorporate an obligation on the contractor to comply with the conditions printed thereon as regards delivery, carriage, documentation, variations, etc.

8.2.15 The Chief Executive must ensure that Forth Valley NHS Board Standing Orders and SFIs are compatible with guidance issued by the Scottish Government Health and Social Care Directorate in respect of building and engineering contracts (PROCODE) and land and property transactions (ESTATECODE). The technical audit of these contracts shall be the responsibility of the relevant Director. The Director of Finance shall ensure that the arrangements for financial control and audit of building and engineering contracts and property transactions comply with the guidance contained within these codes.

8.2.16 In accordance with Scottish Procurement Policy Note SPPN 2/2010 any contractor or sub-contractor performing security industry services will be required to be registered with the SIA Approved Contractors Scheme for the category of security service being provided/performed under the contract.

SECTION 9: INCOME, FEES AND CHARGES

9.1 INCOME SYSTEMS

9.1.1 The Director of Finance shall be responsible for designing and maintaining systems for the proper recording and collection of all monies due, including income due under service agreements for the provision of patient care services. The Director of Finance shall also be responsible for establishing reliable systems for financial coding to properly record all transactions.

9.2 FEES AND CHARGES

9.2.1 Forth Valley NHS Board shall follow the guidance and advice of the Scottish Government Health and Social Care Directorate in setting prices for Service Agreements.

9.2.2 The Director of Finance is responsible for setting prices for chargeable services including non-contracted activity (cross-border) and unplanned activity (UNPACS) cross health board boundary, in accordance with national guidance.

9.2.3 The Director of Finance is responsible for approving and regularly reviewing the level of fees and charges other than those determined by the Scottish Government Health and Social Care Directorate or by Statute.

9.2.4 All employees have a responsibility to inform the Accounting Services Manager of money due to Forth Valley NHS Board arising from transactions which they initiate, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

9.3 DEBT RECOVERY

9.3.1 The Director of Finance is responsible for taking appropriate recovery action on all outstanding debts.

9.3.2 Income not received will be dealt with in accordance with losses procedures.

9.3.3 All staff dealing with income transactions are responsible for ensuring that underpayments against sums due are prevented, but where these occur, recovery action as determined by the Director of Finance should be initiated.

9.3.4 The Director of Finance shall establish procedures for the write-off of debts after all reasonable steps have been taken to secure payment.

SECTION 10: TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND STAFF

10.1 REMUNERATION AND TERMS OF SERVICE

10.1.1 The Board shall establish a Remuneration Committee whose composition and remit will be set out in the Forth Valley NHS Board's standing orders contained in the code of Corporate Governance.

10.1.2 The Remuneration Committee will operate within the Terms of Reference described in the Forth Valley NHS Board's standing orders contained in the code of Corporate Governance.

10.1.3 The remuneration of the Chairperson and Non-Executive Directors will be set in accordance with the instructions issued by the Scottish Ministers.

10.1.4 The Committee shall report in writing to the Board the bases for its recommendations. The Board shall use the report as the basis for their decisions but remain accountable for taking decisions on the remuneration and terms of service of executive directors.

10.2 FUNDED ESTABLISHMENT

10.2.1 The establishment plans incorporated within the annual budget will form the funded establishment of the Forth Valley NHS Board.

10.2.2 The Director of Finance shall be responsible for designing a system of funded establishment control. The funded establishment of any department may only be varied in accordance with the approved establishment control system. As part of this, any changes in the funded establishment will require approval from the relevant professional lead, particularly in relation to skill mix changes.

10.3 STAFF APPOINTMENTS

10.3.1 No director or officer may engage, re-engage or re-grade staff, either on a permanent or temporary basis, or hire agency staff, or agree to changes in any aspect of remuneration unless

(a) so authorised by the Chief Executive; and

(b) within the limit of the approved budget and funded establishment.

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service, job evaluation etc. for employees.

10.3.3 A certified appointment form and such other documents as may be required shall be sent to HR connect for approval immediately upon the employee commencing duty. It is the responsibility of the Manager who is receiving the new team member to complete any paperwork or input information to the electronic employee support systems (eESS) as appropriate.

10.4 CONTRACT OF EMPLOYMENT

10.4.1 Each employee shall be issued with a Contract of Employment by the Director of Human Resources, which shall comply with current employment legislation and be in a form approved by the Board.

10.4.2 The Director of Human Resources shall be responsible for dealing with variations to, or termination of, contracts of employment, including appropriate record-keeping.

10.5 STAFF CHANGES

10.5.1 A variation to contract of employment shall be issued in all cases of changes to existing contract.

10.5.2 Confirmation of a change in the status of employment shall be completed and submitted electronically via eESS.

10.5.3 Termination of employment must be processed via eESS immediately upon the effective date of an employee's resignation, retirement or termination being known. Where an employee fails to report for duty in circumstances which suggest they have left without notice, the Director of Human Resources and the Payroll Manager shall be informed as soon as possible.

10.6 PAYROLL

10.6.1 All pay records, related electronic records and their notification shall be in a form approved by the Director of Finance and shall be certified and submitted in accordance with their instructions.

10.6.2 The Director of Finance shall be responsible for the final determination of any pay including verification that the rate of pay and relevant conditions of service are in accordance with current agreements, the proper compilation of the payroll and for payments made.

10.6.3 The Director of Finance shall determine the dates on which the payment of salaries and wages are to be made, having regard to the general rule that it is undesirable to make payments in advance.

10.6.4 All employees shall be paid monthly by BACS (with the exception of any enhancements, extra hours or overtime which are paid one month in arrears) unless otherwise agreed by the Director of Finance.

10.6.5 All staff have a responsibility to ensure they are being paid correctly. Staff must report immediately to the Payroll Manager any irregular payment which has been made from funds for payroll purposes.

10.7 TRAVEL AND OTHER STAFF EXPENSES

10.7.1 The Board will reimburse reasonable expenses which have been necessarily and exclusively incurred by employees while engaged on approved NHS Forth Valley business in accordance with the relevant terms and conditions of employment.

10.7.2 All expenses claims must be submitted via the NHS Scotland electronic expenses system, or where this is not possible, on the relevant NHS Scotland expenses claim form (there are separate forms for Medical & Dental staff, Agenda For Change staff and leased car users). Claims must be submitted within a maximum of 3 months of the expenses being incurred by the employee. Claims submitted outwith this period will not be reimbursed unless there are exceptional circumstances which must be notified to the Payroll Team in writing by the Service Manager of the Department. A final decision on whether the claim should be reimbursed will rest with the Director of Finance.

10.7.3 The Director of Finance shall reimburse all expenses claimed by employees of the Board or outside parties in line with the relevant Agenda For Change regulations, General Whitley Council regulations, Hospital, Medical and Dental Whitley Council regulations and His Majesty's Revenue & Customs (HMRC) regulations, as appropriate. Arrangements for the certification of such claims by the appropriate Head of Department shall be subject to the approval of the Director of Finance.

10.7.4 The Director of Finance shall ensure that HMRC regulations with regard to travel and other staff expenses are complied with.

SECTION 11: ACCOUNTS PAYABLE

11.1 RESPONSIBILITIES FOR NOTIFYING AND MAKING PAYMENTS

11.1.1 All employees must comply with the approved scheme of delegation contained in the Board's Standing Orders when initiating all non-pay transactions.

11.1.2 The Director of Finance shall be responsible for the prompt payment of all properly authorised invoices and claims. Payment of contract invoices shall be undertaken promptly in accordance with contract terms, or otherwise, in accordance with the Scottish Government prompt payment policy.

11.1.3 All Directors, officers and agents shall inform the Director of Finance promptly of all monies payable by Forth Valley NHS Board arising from transactions which they initiate, including contracts, leases, tenancy agreements and other transactions.

11.1.4 Payments to independent Family Health Service Practitioners and all associated administration has been delegated to NHS National Services Scotland (NSS) under a Partnership Agreement. NSS will act as agents of the Board in accordance with the Partnership Agreement.

11.2 SYSTEMS AND PROCEDURES FOR MAKING PAYMENTS

11.2.1 The Director of Finance shall be responsible for designing and maintaining a system for the verification, recording and payment of all amounts payable by Forth Valley NHS Board. The system shall provide for:

(a) a list of officers authorised to certify invoices, together with specimens of their signatures (the authorised signatory database)

(b) certification that:

- goods have been received or services supplied as agreed;
- where contracts are based on measurement of time, materials, or expenses, that each are in accordance with the appropriate independent certified measures;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the invoice or claim is arithmetically correct;

- the invoice or claim is not a duplicate and has not been paid previously, and

- the VAT treatment is correct.

(c) a timetable for payments to be made; provision shall be made for the early submission of accounts where cash discounts can be obtained or for those accounts which otherwise require early payment;

(d) instructions to employees regarding the handling and payment of accounts by the Accounts Payable team;

(e) a process which ensures that payment for goods and services is only made once the goods and services have been received by Forth Valley NHS Board (except as allowed for below), and

(f) appropriate segregation of duties.

11.2.2 In the case of contracts for building or engineering works, which require payment to be made on account during progress of the works, the Director of Finance shall make payment on receipt of a certificate from the appropriate technical consultant. Without prejudice to the responsibility of any consultant or works officer appointed to a particular building or engineering contract, a contractor's account shall be subject to such financial examination by the Director of Finance and such general examination by a works officer as may be considered necessary, before the person responsible to Forth Valley NHS Board for the contract, issues the final certificate.

11.2.3 Where a contract is based on the measurement of time, materials or expenses, the checks to be carried out must provide confirmation that:

(a) the time charged is in accordance with the time sheets

(b) the rates of labour are in accordance with the appropriate rates

(c) the materials have been checked as regards quantity, quality, and price

(d) the charges for the use of vehicles, plant and machinery have been examined

11.2.4 Where an officer certifying accounts or claims relies upon other officers to do preliminary checking, they shall, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms.

11.2.5 Payment in advance may also be approved for items such as courses, conferences and travel where payment is required to secure the booking, or where it is necessary to use corporate credit card.

11.3 OTHER

11.3.1 All employees must comply with the NHS Scotland Conduct policy and the local standards of business conduct policy. Any query on the application of the standards must be raised with the Director of Human Resources.

SECTION 12: CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

12.1 FRAUD POLICY AND RESPONSE PLAN

12.1.1 The Director of Finance shall prepare a Fraud Policy and Response Plan which shall be approved by the Board.

12.2 DISPOSALS AND CONDEMNATIONS

12.2.1 The Director of Finance shall prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

12.2.2 When it is decided to dispose of an asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

12.2.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the condemning officer in a form approved by the Director of Finance, which will indicate whether the articles are to be converted, destroyed, or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

12.2.4 The condemning officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report such evidence to the Director of Finance who will take the appropriate action.

12.3 LOSSES AND SPECIAL PAYMENTS

12.3.1 The Director of Finance shall prepare procedural instructions on the recording of and accounting for losses and special payments.

12.3.2 Any officer discovering or suspecting a loss of any kind shall forthwith inform their Head of Department, who shall immediately inform the Chief Executive and Director of Finance.

12.3.3 Where a criminal offence is suspected, the Board's Fraud Policy and Response Plan will be implemented.

12.3.4 The Director of Finance shall notify the Scottish Government Health and Social Care Directorate of all losses and special payments, including those arising from fraud in accordance with CEL (2010) 10 and report this via Scottish Financial Return (SFR) 18.0 to 18.2.

12.3.5 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Director of Finance shall immediately notify:

(a) the Forth Valley NHS Board

(b) the Statutory Auditor

12.3.6 All reported instances of fraud (including any relating to independent Family Health Services Practitioners) and other cases as may be determined by Scottish Government Health and Social Care Directorate, will be referred to the NHS Scotland Counter Fraud Service in accordance with guidance received from Scottish Government Health and Social Care Directorate.

12.3.7 All legal claims brought against the Board must be directed to the Central Legal Office who will manage them on the Board's behalf under the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS). An updated register of ongoing cases and expected losses will be issued to the Board periodically by the CNORIS Team.

12.4 WRITING OFF OF LOSSES

12.4.1 The Board has delegated authority to write-off losses and make special payments up to certain limits as detailed in the Scheme of Delegation. Prior approval must be obtained from SGHSCD for amounts exceeding this.

12.4.2 The Director of Finance shall maintain a losses and compensation register in which details of all losses shall be recorded, as they are known. Write-off action shall be recorded against each entry in the register.

12.4.3 The Director of Finance shall be authorised to take any necessary steps to safeguard Forth Valley NHS Board interest in bankruptcies and company liquidations.

12.4.4 No special payments exceeding the delegated limits determined by the Board shall be made without the prior approval of the Director of Finance.

12.4.5 Losses are classified in accordance with the relevant SFRs as outlined in the NHS Scotland Accounts Manual issued by the Scottish Government Health and Social Care Directorate.

12.4.6 The delegated limits of authority for each type of loss are contained in the Scheme of Delegation included in the Board's Code of Corporate Governance.

12.4.7 A statement of Losses and Special Payments requires to be reported within the Annual Report and Accounts. Individual losses or special payments exceeding £300,000 must be reported separately.

SECTION 13: ENDOWMENTS AND TRUST FUNDS (NON-EXCHEQUER FUNDS)

13.1 INTRODUCTION

13.1.1 Endowment and Trust Funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the National Health Service, the objects of which are for the benefit of the National Health Service in Scotland. They are administered by the Board acting as trustees or by Special Trustees appointed by the Scottish Ministers or by other persons under a trust. An Endowments Committee will be responsible for the management of Forth Valley NHS Board Endowment and Trust Funds.

13.1.2 The discharge of the Board's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence, and propriety.

13.1.3 These Standing Financial Instructions shall apply equally to Non-Exchequer Funds as to other funds except that expenditure from Non-Exchequer Funds shall be restricted to the purpose(s) of the appropriate Fund.

13.1.4 The Director of Finance shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of Forth Valley NHS Board as trustees of non-exchequer funds, including an Investments Register.

13.1.5 All share and stock certificates and property deeds shall be deposited either with Forth Valley NHS Board Bankers or Investment Advisers, or in a safe, or a compartment within a safe, to which only a designated responsible officer will have access.

13.1.6 The Director of Finance shall prepare detailed procedural instructions concerning the receiving, recording, investment, and accounting for endowment funds.

13.1.7 The Director of Finance shall be required to advise the Board on the financial implications of any proposal for fund raising activities, which Forth Valley NHS Board may initiate, sponsor, or approve.

13.1.8 The Director of Finance shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. After the death of a testator all correspondence concerning a legacy shall be dealt with on behalf of Forth Valley NHS Board by the Director of Finance who alone shall be empowered to give an executor a good discharge.

13.1.9 Endowment and Trust Funds shall be invested by the Director of Finance in accordance with Forth Valley NHS Board policy and subject to statutory requirements. The Director of Finance shall have authority to obtain professional advice on investments.

13.1.10 Where it becomes necessary for Forth Valley NHS Board to obtain Grant of Probate, or to make application for grant of letters of administration, in order to obtain a legacy due to Forth Valley NHS Board under the terms of a Will, the Director of Finance shall be Forth Valley NHS Board nominee for the purpose.

SECTION 14: INFORMATION MANAGEMENT

14.1 RESPONSIBILITIES

14.1.1 The Chief Executive shall be responsible for ensuring the maintenance of archives for all documents required to be retained under the direction contained in CEL (31)2010 and the requirements of the Freedom of Information Act 2002 and the Public Records (Scotland) Act 2011.

14.1.2 The documents held in archives shall be capable of retrieval by authorised persons. Stirling University provides archive services for the Board.

14.1.3 Documents held shall only be destroyed at the express instigation of the Chief Executive in line with approved retention schedules.

14.1.4 The Director of Finance will act as Senior Information Risk Officer (SIRO) for NHS Forth Valley. The SIRO is a mandatory role for public sector organisations and has oversight of information risks within the organisation. The SIRO will inform and advise the board on how to mitigate these risks in accordance with the organisation's risk appetite.

14.1.5 The Director of Finance shall be primarily responsible for the accuracy and security of the computerised financial data of Forth Valley NHS Board and will formally record this is part of the Board's Information Asset Register.

14.2 FINANCIAL SYSTEMS MANAGEMENT

14.2.1 The Board's financial system (eFinancials) is a national single instance financial system operated and maintained by NHS Ayrshire and Arran on behalf of all NHS Boards in Scotland. The eFinancials software is supplied and supported by OneAdvanced and interfaces with a number of NHS Scotland's procurement, payroll and payment systems. An annual service audit is commissioned by NHS Ayrshire and Arran to provide assurance to all NHS boards that appropriate and effective system controls are in place.

14.2.2 The Director of Finance shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of Forth Valley NHS Board and individuals from inappropriate use or misuses of any financial and other information held on computer files, for which he is responsible after taking into account relevant legislation (including UK-GDPR and the Data Protection Act 2018), the Network and Information Systems Regulations 2018, the Freedom of Information (Scotland) Act 2002, and the Computer Misuse Act 1990.

(b) ensure that adequate data controls exist over data entry, processing, storage, transmission, and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system, including the use of any external agency arrangement.

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance, and amendment.

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they may consider necessary are being carried out.

(e) ensure that contingency planning is undertaken and that adequate contingency arrangements are in place.

14.2.3 The Director of Finance shall satisfy themself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

14.2.4 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy themself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as the Digital Healthcare Strategy

(b) data produced for use with financial systems is adequate, accurate, complete, timely and in a form determined by the Director of Finance, and that a management (audit) trail exists

(c) finance staff have access to such data

(d) such computer audit reviews as are considered necessary are being carried out

SECTION 15: INTERNAL AND EXTERNAL AUDIT

15.1 AUDIT AND RISK COMMITTEE

15.1.1 In accordance with Standing Orders (and as set out in DL (2019) 02 and the Blueprint for good governance in NHS Scotland 2nd edition published in Nov 2022), the Board shall establish an Audit and Risk Committee which will provide an independent and objective view of when considering the following;

(a) Internal control and corporate governance

(b) Internal Audit including the approval of the Strategic Audit Plan

(c) External Audit

(d) Standing Orders and Standing Financial Instructions

(e) Accounting Policies

(f) Annual Accounts (including the schedule of losses and compensations)

(g) Risk Management

15.1.2 Where the Audit and Risk Committee consider there is evidence of ultra-vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chairperson of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Scottish Government Health and Social Care Directorate.

15.1.3 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided to Forth Valley Health Board and that this is reviewed regularly by the Audit Committee. The Audit Committee should be consulted on any decision to change the internal audit service provider and shall participate in the selection process for any new service provider.

15.2 DIRECTOR OF FINANCE

15.2.1 The Director of Finance shall be responsible for ensuring that internal audit is adequate for the needs of NHS Forth Valley and meets the NHS mandatory audit standards. The Director of Finance will ensure that there are arrangements to measure, evaluate and report on the effectiveness of internal control and efficient use of resources by the establishment of an adequate internal audit function headed by a Chief Internal Auditor of sufficient status.

15.2.2 It shall be the responsibility of the Director of Finance to review, appraise, and to report to management upon the adequacy of follow-up action to Audit Reports in accordance with the policy approved by the Audit Committee, which shall be reviewed at least biennially.

15.2.3 The Director of Finance shall ensure that an annual internal audit report is prepared by the Chief Internal Auditor and presented to the Audit Committee, in accordance with its timetable which contains:

(a) a clear statement on the adequacy and effectiveness of internal control

(b) details of major internal control weaknesses discovered

(c) a summary of progress against plan in the previous year

(d) quality measures as defined within the service specification

15.2.4 The Director of Finance shall be notified immediately whenever any matter arises which involves, or is thought to involve, irregularities involving cash, stores, other property of Forth Valley Health Board, or any suspected irregularity in the exercise of any function of a financial nature and shall inform the Chief Internal Auditor. The Director of Finance shall comply with the requirements of the Scottish Government Health and Social Care Directorate and of the Board's Fraud Policy in the resolution of these matters.

15.3 INTERNAL AUDIT

15.3.1 The Chief Internal Auditor shall be responsible directly to the Director of Finance for the provision of a professional and comprehensive Internal Audit Service to Forth Valley Health Board. In carrying out this responsibility the Chief Internal Auditor shall normally attend the meetings of the Audit and Risk Committee and will have the right of direct access to the Chief Executive, the Chairperson, or other members of the Audit and Risk Committee.

15.3.2 The objectives and scope of Internal Audit are set out in the Public Sector Internal Audit Standards (PSIAS) and the Board's approved audit charter. Internal Audit will review, appraise, and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures

(b) the adequacy and application of financial and other related management controls

(c) the suitability of financial and other related management data

(d) the extent to which Forth Valley Health Board assets and interests are accounted for and safeguarded from loss of any kind, arising from:
- fraud and other offences
- waste, extravagance, or inefficient administration
- poor value for money
- other causes.

15.3.3 The Chief Internal Auditor shall be entitled, without necessarily giving prior notice, to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case he shall have a duty to safeguard the confidentiality);

(b) access to any land, premises, or employee of the Board;

(c) the production or identification by any employee of any Board cash, stores, or other property under the employee's control;

(d) explanations concerning any matter under investigation or review.

15.3.4 Where a matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property of the Board, or any suspected irregularity in the function of a pecuniary nature, officers shall act in accordance with the provisions of Section 12 of the SFIs, the Board's Fraud Policy, relevant Financial Operating Procedures and the requirements of the Scottish Government Health and Social Care Directorate.

15.3.5 The Chief Internal Auditor shall report in accordance with the reporting protocol approved by the Audit Committee which shall be reviewed at least biennially.

15.3.6 Counter Fraud Service (CFS) staff acting on the Director of Finance's behalf may require and receive access to:

- All records, documents and correspondence relating to transactions relevant to an investigation.

- At all reasonable times to any premises or land of NHS Forth Valley.

15.4 EXTERNAL AUDIT

15.4.1 The External Auditors for Forth Valley Health Board are appointed by the Auditor General for Scotland. The audit appointments are rotated on a five year cycle in order to maintain External Auditors' independence.

15.4.2 The appointed External Auditor's statutory duties are contained in the Public Finance and Accountability (Scotland) Act 2000 and these are undertaken from a wider perspective than audits conducted in the private sector.

15.4.3 The External Auditor is concerned with providing an independent assurance of the Board's financial stewardship including value for money, probity, material accuracy, compliance with guidelines and accepted accounting practice for NHS accounts. However they will also consider additional aspects or risks in financial management, financial sustainability, vison, leadership and governance and the use of resources to improve outcomes.

15.4.4 The appointed External Auditor has a general duty to satisfy themself that:

(a) The Board's accounts have been properly prepared in accordance with the directions given under the Public Finance and Accountability (Scotland) Act 2000

(b) Proper accounting practices have been observed in the preparation of the accounts

(c) The Board has made proper arrangements for securing best value in the use of its resources

15.4.4 Additionally, Audit Scotland's Code of Audit Practice which covers the conduct of the audit, requires the appointed External Auditor to consider whether the statement of accounts represents a true and fair view of the financial position of the Board.

15.4.5 The External Auditor is required to provide an Audit Certificate and opinion to Forth Valley Health Board, Scottish Ministers and Audit Scotland. They are also required to submit a final report to members of Forth Valley Health Board, which summarises significant matters arising during the statutory audit. The auditor will also normally issue management letters to the Chief Executive and the Director of Finance highlighting any significant matters during the course of the audit.

15.4.6 The appointed External Auditor has special duties to report directly to the Auditor General should he have reason to believe that a Board decision would involve unlawful expenditure or would be unlawful and cause a loss or deficiency.

SECTION 16: ANNUAL REPORT AND ACCOUNTS

16.1 GENERAL

16.1.1 Forth Valley NHS Board is required under the terms of Section 86(3) of the National Health Service (Scotland) Act 1978 to prepare and submit Annual Accounts to Scottish Ministers.

16.1.2 The Director of Finance, on behalf of the Forth Valley NHS Board, shall prepare, certify, and submit annual accounts to the Chief Executive in such a form as directed by the Scottish Ministers and in accordance with the guidance and timetable laid down by the Scottish Government Health and Social Care Directorate.

16.1.3 The annual accounts are a public report on the financial and governance affairs of the NHS Board during the financial year and are laid before the Scottish Parliament. The annual accounts are comprised of the financial statements together with an annual report which consist of a performance report and accountability report.

16.1.4 The Annual Report and Accounts must comply with the accounting and disclosure requirements of the Government Financial Reporting Manual (FReM) as issued by HM Treasury for the year being reported on. Guidance in this NHS Board Annual Accounts Manual for the relevant year must also be followed.

16.1.5 The Board's Annual Accounts must be independently audited by an auditor appointed by the Auditor General for Scotland under the terms and provisions of the Public Finance and Accountability (Scotland) Act 2000.

16.1.6 On receipt of the audited Annual Accounts and the associated Management Letter, the Director of Finance shall:

(a) present the proposed management response for consideration by the Audit and Risk Committee;
(b) ensure that the accounts are presented to and approved by the Board at a Board meeting
(c) submit by the 30th of June each year to the Scottish Government to be laid before Parliament before being published.

16.1.7 The Director of Finance shall prepare and submit annually a financial report to the Board detailing the overall performance for the preceding financial year.

SECTION 17: STORES AND RECEIPT OF GOODS

17.1 GENERAL RESPONSIBILITIES

17.1.1 The Chief Executive shall delegate to an officer of Forth Valley NHS Board the responsibility for the overall control of stores.

17.1.2 The Director of Finance shall be responsible for design and implementation of the systems of control.

17.1.3 The day to day management of stores may be delegated to departmental officers and Stores Managers/Keepers, subject to such delegation being entered in a record available to the Director of Finance.

17.2 SECURITY ARRANGEMENTS

17.2.1 The responsibility for security arrangements and the custody of keys for all stores locations shall be clearly defined in writing by an officer delegated by the Chief Executive and agreed with the Director of Finance.

17.3 SYSTEMS AND STORES CONTROL

17.3.1 All stores' records shall be in such form and shall comply with such system of control as the Director of Finance shall approve.

17.3.2 The Director of Finance shall set out procedures and systems to regulate stores transactions including records for receipt of goods from store and returns to store.

17.3.3 Wherever practicable stocks shall be marked as health service property.

17.3.4 Controlled stores and department stores established for immediate use should be:

(a) maintained at the minimum practicable store levels related to operational requirements
(b) subject to a regular stock takes (either as part of a rolling programme or a full annual stock take)
(c) valued at the lower of cost or net realisable value

17.3.5 The nominated manager/pharmaceutical officer shall be responsible for a system, approved by the Director of Finance, for a review of slow moving and obsolete items and for the condemnation, disposal, and replacement of unserviceable articles. The designated officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (See Section 12). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

17.3.6 Stock levels should be kept to a minimum consistent with operational efficiency.

17.3.7 Stocktaking arrangements shall be agreed with the Director of Finance, with either an agreed physical rolling programme of stock takes throughout the year or a full

annual stock take. However, depending on the value and marketability of some items, a system of perpetual inventory checking may be applied.

17.3.8 Those stores designated by the Director of Finance as comprising more than 7 days of normal use should be:

(a) subjected to annual or continuous stock-take
(b) valued at the lower of cost and net realisable value

SECTION 18: PATIENTS' PROPERTY

18.1 GENERAL

18.1.1 Forth Valley NHS Board has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

18.1.2 The Chief Executive shall be responsible for informing patients or their guardians, as appropriate, before or at admission, that the Board will not accept responsibility or liability for patient's property brought into health service premises, unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt.

18.1.3 The Director of Finance shall provide detailed written instructions for the receipt, custody, recording, safekeeping, and disposal of patient's property (including instructions on the disposal of the property of deceased patients and patients transferred to other premises) for all staff who have responsibility for the property of patients. The Director of Finance will also have procedures in place to deal with the loss of patients' property.

18.1.4 Where Scottish Government Health and Social Care Directorate instructions require the opening of separate accounts for patients' monies as part of Corporate Appointee duties, these shall be opened and operated under arrangements agreed by the Director of Finance.

18.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

18.1.6 The Director of Finance will ensure there are instructions and guidance for managing the funds of patients with incapacity who are unable to manage their own financial affairs. Funds may be managed either through DWP Appointeeship, or where necessary, powers delegated to ward managers by NHS Forth Valley under part 4 of the Adults with Incapacity (Scotland) Act 2000.

18.1.7 Staff should be informed on appointment, by the appropriate departmental or senior manager, of their responsibilities and duties for the administration of the

property of patients. Staff will be expected to familiarise themselves with the relevant financial operating procedures in respect of patients property.

18.1.8 Where patients' property or income is received for specific purposes and held for safekeeping, the property of income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

18.1.9 The Director of Finance shall prepare an abstract of receipts and payments of patients' private funds in the form laid down in the Board Accounts Manual. This abstract shall be audited independently and presented to the Audit Committee annually, with the auditor in attendance at the meeting.

SECTION 19: RISK MANAGEMENT

19.1 GENERAL

19.1.1 The Chief Executive shall ensure that Forth Valley NHS Board has a risk management strategy which sets out the principles and approaches to risk management that will be followed in relation to risks that could threaten achievement of business objectives. The risk management strategy will be approved and monitored by the Forth Valley NHS Board.

19.1.2 The programme of risk management shall include, inter alia:

a) a process for identifying and quantifying risks and potential liabilities including those arising from the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS)
b) engendering among all levels of staff a positive attitude towards the control of risk
c) management processes to ensure that all significant risks and potential liabilities are mitigated as far as possible, including effective systems of internal control and decisions on the acceptable level of retained risk
d) contingency plans to offset the impact of adverse events
e) audit arrangements including external and internal audit, clinical audit, health, and safety review
f) arrangements to review the risk management programme
g) development of a financial risk management strategy to cope with possible in-year variations to the initially set budget

19.1.3 The existence, integration and evaluation of the above elements will provide a basis for the Audit and Risk Committee to make a statement on the effectiveness of internal control and corporate governance to Forth Valley NHS Board.

SECTION 20: PRIMARY CARE CONTRACTORS

20.1 GENERAL

20.1.1 The Practitioner and Counter Fraud Services Division (PCFS) of NHS National Services Scotland (NSS) is the payment agency for all Family Health Service (FHS) contractor payments due to:

(a) General Practitioners
(b) Dentists
(c) Community Pharmacists
(d) Optometrists

20.1.2 The Director of Finance shall conclude a “Partnership Agreement” with the PCFS division covering validation, payment, monitoring, reporting and the provision of an audit service by the NSS service auditors. The agreement will be signed off by the Chief Executive of NHS Forth Valley.

20.1.3 The Board will approve additions to, and deletions from, the approved performers list of FHS contractors in line with the National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004 and other applicable guidance and regulations, including consideration of the health needs of the local population and access to existing services. All applications and resignations received will be dealt with equitably, within any time limits laid down in the relevant contractors’ NHS terms and conditions of service.

20.1.4 The Director of Finance will:

(a) ensure that lists of all contractors are maintained and kept up to date; and
(b) ensure that systems are in place to deal with applications, resignations, inspection of premises, etc. within the appropriate contractor’s terms and conditions of service.

20.1.5 The Director of Finance shall ensure that NSS systems are in place to provide assurance that:

(a) only contractors who are included on the Board’s approved lists receive payments;
(b) all valid contractors’ claims are paid correctly, and are supported by the appropriate documentation and authorisations
(c) any payments to third parties are notified to the Independent Contractors on whose behalf payments are made
(d) ensure that regular independent pre and post payment verification of claims is undertaken to confirm that:

- payment criteria/eligibility rules have been correctly and consistently applied
- overpayments are prevented wherever possible; if, however, overpayments are detected, recovery measures are initiated
- fraud is detected and instances of actual and potential fraud are followed up

(e) exceptionally high/low payments are identified and escalated
(f) payments made via NSS are reported to NHS Forth Valley as appropriate
(g) local payments made on behalf of the Board by NSS are pre-authorised
(h) payments made by NSS are reconciled with the cash draw-down reported by the Scottish Government Health and Social Care Directorate to the Board

20.1.6 The Director of Finance shall prepare operating procedures to cover all payments made by NSS (both payments made directly, or payments made on behalf of the Board and/or Contractors).

20.1.7 Payments made to all FHS independent contractors shall comply with their appropriate contractor regulations.

SECTION 21: STANDARDS OF BUSINESS CONDUCT

21.1 GENERAL

21.1.1 Detailed information is available in the NHS Scotland Conduct policy and the local NHS Forth Valley Policy on Standards of Business Conduct.

21.1.2 MEL (1994) 80 also provides details of the principles for standards of conduct and accountability in situations when there is potential conflict between the private interests of NHS staff and their duties.

21.1.3 It will be the responsibility of the Chief Executive to:

(a) ensure that the NHS Scotland conduct policy, any local conduct policy and all Scottish Government Health and Social Care Directorate guidelines on standards of business conduct for NHS staff as per MEL (1994) 48 are brought to the attention of all staff, and are effectively implemented
(b) develop local conflict of interest policies and the machinery to implement them, in consultation with staff and local staff representatives
(c) ensure that such policies and procedures are kept up to date
(d) ensure that a full operational policy on the Standards of Business Conduct is developed and communicated to staff

21.1.4 The business of the Board will be conducted in accordance with the Ethical Standards in Public Life etc (Scotland) Act 2002. All members of staff have a duty to maintain strict ethical standards in the conduct of their business as an employee of Forth Valley NHS Board.

21.1.5 It is the responsibility of all staff when acting on NHS Forth Valley's behalf to:

- conduct the business of the organisation professionally, with honesty, integrity, free from bribery and maintain the organisations reputation
- if staff are in any doubt as to what they can or cannot do they must seek advice from their line manager or from the Human Resources Department.
- Note that breaches may lead to disciplinary action or to dismissal.

21.2 BRIBERY ACT 2010

21.2.1 The Bribery Act 2010 is one of the strictest pieces of legislation on bribery and makes it a criminal offence for any individual (employee, contractor, agent) associated with NHS Forth Valley to give, promise or offer a bribe or to request, agree to receive or accept a bribe (section 1,2 and 6 offences). This can be punishable for an individual by imprisonment of up to 10 years.

21.2.2 In addition, the Act introduces a corporate offence (section 7 offence) which means that NHS Forth Valley can be exposed to criminal liability, punishable by an unlimited fee if it fails to prevent bribery by not having adequate preventative procedures in place that are robust, up-to-date, and effective. The corporate offence is not a standalone offence and would follow a bribery/corruption offence committed by an individual associated with NHS Forth Valley in the course of their work.

21.2.3 If a bribery offence is proved to have been committed by an outside body corporate with the consent or connivance of a Director or Senior Officer of NHS Forth Valley, under the Act the Director or Senior Officer would be guilty of an offence (Section 14 offences) as well as the body corporate which paid the bribe.

21.2.4 Whilst the exact definition of bribery and corruption is a statutory matter, the following working definitions are given:

- Bribery is an inducement or reward offered, promised, or provided to gain any commercial, contractual, regulatory, or personal advantage.

- Broadly, the Act defines bribery as giving or receiving a financial or other advantage in connection with the improper performance of a position of trust, or a function that is expected to be performed impartially or in good faith.

- Bribery does not have to involve cash, or an actual payment exchanging hands and can take many forms such as a gift, lavish treatment during a business trip or tickets to an event.

- Corruption relates to a lack of integrity or honesty including the use of trust for dishonest gain. It can broadly be defined as the offering or acceptance of inducements, gifts, favours, payments, or benefits in kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly however they may be unreasonably using their position to give some advantage to another.

21.2 GIFTS, HOSPITALITY, AND INDUCEMENTS

21.2.1 The policy on the Standards of Business Conduct applies to all members of staff at all times.

21.2.2 Officers of Forth Valley NHS Board should not accept business gifts, but articles of a low intrinsic value such as chocolates, biscuits, business diaries or calendars, need not necessarily be refused. No gifts of alcohol should be accepted. Acceptance of gifts over £25 but under £200 require to be authorised by Line Management. Gifts over £200 require to be authorised by Head of Service or Director.

21.2.3 Care should be taken when accepting hospitality. All hospitality offered, such as lunches and dinners, corporate hospitality events, etc should be reported to the officer's superior before acceptance.

21.2.4 Any inducements offered should be reported to the officer's superior.

21.2.5 Visits at suppliers' expense to inspect equipment etc should not be undertaken without the prior approval of the Chief Executive and in the case of the Chief Executive by the prior approval of the Chairperson.

21.2.6 A register to record all gifts received by staff with a value over £25 is maintained by the Corporate Services Department and it is the responsibility of the recipients of such gifts to report all such items received. The form 'Declaration of Staff interests and Gifts/Hospitality' (Annex 2 of the Policy on Standards of Business Conduct' should be used for this purpose). This register will be published on the NHS Forth Valley website.

21.3 ACQUISITION OF GOODS AND SERVICES

21.3.1 If officers are involved in the acquisition of goods and services, they should adhere to the ethical code of the Institute of Purchasing and Supply.

21.3.2 Officers should ensure that acceptance of commercial sponsorship will not influence or jeopardise purchasing decisions.

21.4 DECLARATION OF INTERESTS

21.4.1 To avoid conflicts of interest and to maintain openness and accountability all directors, members of staff and non-executive board members have a responsibility to promptly declare relevant interests and any changes to those interests that may arise from time to time.

21.4.2 Employees are required to register all interests that may have any relevance to their duties/responsibilities. These include any financial interest in a business or any other activity or pursuit that may compete for an NHS contract to supply either goods or services to the NHS or in any other way that could be perceived to conflict with the interests of NHS Forth Valley. The test to be applied when considering appropriateness of registration of an interest is to ask whether a member of the public acting reasonably might consider the interest could potentially affect the individual's responsibilities to the organisation and/or influence their actions. If in doubt the individual should register the interest or seek further guidance from the Corporate Services Department.

21.4.3 Interests that it may be appropriate to register include:-

(i) Other employment including self-employment

(ii) Directorships including Non-Executive Directorships held in private companies or public limited companies whether remunerated or not

(iii) Ownership of, or an interest in private companies, partnerships, businesses, or consultancies

(iv) Shareholdings in organisations likely or possibly seeking to do business with the NHS (the value of shareholdings need not be declared)

(v) Ownership of or an interest in land or buildings which may be significant to, of relevance to, or bear upon the work of NHS Forth Valley

(vi) Any position of authority held in another public body, trade union, charity, or voluntary body

(vii) Any connection with a voluntary or other body contracting for NHS services

(viii) Any involvement in joint working arrangements with Clinical or other Suppliers

21.4.4 This list is not exhaustive and should not preclude the registration of other forms of interest where these may give rise to a potential conflict of interest upon the work of NHS Forth Valley. Any interests of spouses, partner or civil partner, close relative or associate or persons living with the individual as part of a family unit will also require registration if a perceived or actual conflict of interest exists.

21.4.5 Forth Valley NHS Board will maintain a Register of Interests and publish this on the Board's website

SECTION 22: SUSPECTED THEFT, FRAUD & OTHER FINANCIAL IRREGULARITIES

22.1 INTRODUCTION

22.1.1 The following procedures should be followed, as a minimum, in cases of suspected theft, fraud, embezzlement, corruption or other financial irregularities to comply with the NHS Scotland Counter Fraud Service Strategy and the Board's local fraud policies and protocols. This procedure also applies to any non-public funds.

22.2 THEFT, FRAUD, EMBEZZLEMENT, CORRUPTION AND OTHER FINANCIAL IRREGULARITIES

22.2.1 The Chief Executive has the responsibility to designate an officer within the Board with specific responsibility for co-ordinating action where there are reasonable grounds for believing that an item of property, including cash has been stolen.

22.2.2 It is the designated officer's responsibility to inform as they deem appropriate the police, the Counter Fraud Services (CFS), the appropriate director, the Appointed Auditor, and the Chief Internal Auditor where such an occurrence is suspected.

22.2.3 Where any officer of the Board has grounds to suspect that any fraud related activities has occurred, their line manager should be notified without delay. Line managers should in turn immediately notify the Board's Director of Finance, who should ensure consultation with the CFS, normally via the Chief Internal Auditor. It is essential that preliminary enquiries are carried out in strict confidence and with as much speed as possible.

22.2.4 If, in exceptional circumstances, the Director of Finance and the Chief Internal Auditor are unavailable the line manager will report the circumstances to the Chief Executive who will be responsible for informing the CFS. As soon as possible thereafter the Director of Finance should be advised of the situation.

22.2.5 Where preliminary investigations suggest that prima facie grounds exist for believing that a criminal offence has been committed, the CFS will undertake the investigation, on behalf of, and in co-operation with, the Board. At all stages the

Director of Finance and the Chief Internal Auditor will be kept informed of developments on such cases. All referrals to the CFS must also be copied to the Appointed Auditor.

22.3 REMEDIAL ACTION

22.3.1 As with all categories of loss, once the circumstances of a case are known the Director of Finance will require to take immediate steps to ensure that so far as possible these do not recur. However, no such action will be taken if it would prove prejudicial to the effective prosecution of the case. It will be necessary to identify any defects in the control systems, which may have enabled the initial loss to occur, and to decide on any measures to prevent recurrence.

22.4 REPORTING TO THE SCOTTISH GOVERNMENT HEALTH AND SOCIAL CARE DIRECTORATE

22.4.1 While normally there is no requirement to report individual cases to the Scottish Government Health and Social Care Directorate, there may be occasions where the nature of scale of the alleged offence, or the position of the person or persons involved, could give rise to national or local controversy and publicity. Moreover, there may be cases where the alleged fraud appears to have been of a particularly ingenious nature or where it concerns an organisation with which other health sector bodies may also have dealings. In all such cases the Scottish Government Health and Social Care Directorate must be notified of the main circumstances of the case at the same time as an approach is made to the CFS.

22.5 RESPONSES TO PRESS ENQUIRIES

22.5.1 Where the publicity surrounding a particular case of alleged financial irregularity attracts enquiries from the press or other media, the Chief Executive should ensure that the relevant officials are fully aware of the importance of avoiding issuing any statements, which may be regarded as prejudicial to the outcome of criminal proceedings.

APPENDIX A: TENDERING AND CONTRACT PROCEDURES

1. TENDERING PROCESS

1.1 The Chief Executive shall prescribe standard terms and conditions of contract appropriate to each class of supplies and services and for the execution of all works. All contracts entered into shall incorporate the appropriate set of terms and conditions.

1.2 All invitations to potential contractors to tender shall include a notice, warning tenderers of the consequences of engaging in any corrupt practices involving Board employees.

1.3 In the event of tenders being required, notification should be sent to the Corporate Business Manager (Chief Executive's Office) providing details of the tender request sent out, specification, closing date and time and the number of anticipated submissions.

1.4 A record will be maintained of all invitations to tender.

1.5 Tenders shall be invited in plain sealed envelopes addressed to the Chief Executive. The envelope shall be marked 'Tender for ……' but shall not bear the name or identity of the sender.

1.6 Unopened tenders shall be date stamped and stored unopened in a secure place until after the closing date or time.

1.7 Tenders shall be opened as soon as possible after the stated closing date or time by the officer nominated by the Chief Executive, in the presence of an independent witness, normally from the Finance Directorate.

1.8 Details of each tender received should be entered into a register or record of tenders and will be signed by both officers. Tender documents shall also be date stamped and signed on the front page and all priced pages initialled by both officers.

1.9 Where it is in the interests of the Board, late, amended, incomplete, qualified, or not strictly competitive tenders may be considered. In such circumstances a full report shall be made to the Chief Executive who may admit such tenders. This approval must be given in writing by the Chief Executive. Where a Company invited to tender requests a delay in the submission, deferment, if approved, shall be notified to all the Companies concerned. A record of all delays requested, and the outcome of the request shall be maintained.

1.10 The examination of the tenders received shall include a technical assessment, and a written report on the result, containing a recommendation should be made to the Chief Executive. At the same time, staff responsible for making this recommendation shall declare in writing that they have no pecuniary interest in the recommended Company.

1.11 The Chief Executive may accept the tender provided it is the lowest cost (or for disposals the highest sales price) and has been recommended for acceptance, and that on the advice of the Director of Finance, financial provision is available within the overall Board resource. If it is proposed to accept a tender other than the lowest cost,

the Chief Executive will record the reason for this decision. e.g., best overall lifetime cost.

1.12 All officers shall follow any relevant guidance issued by the Scottish Government Health and Social Care Directorate.

1.13 Payment under the contract shall be made by the Director of Finance who shall have the right to carry out such financial examinations and checks as considered necessary before making payment.

1.14 Approval for increases in prices allowed under an appropriate variation of prices clause in a contract for supplies and services shall be given by the Chief Executive.

1.15 No contract for the purchase of computer equipment or software outwith the eHealth Department shall be entered into without the Director of Finance's prior written approval.

1.16 Post-tender negotiation may be undertaken where it is anticipated that such action will reduce cost to the Board and where such negotiation has specially been approved in advance by the Chief Executive and Director of Finance. In such circumstances the negotiation must take place with not less than two employees of the Board present both of whom must be approved for the purpose by the Chief Executive. A record of the names of those present at the negotiation must be kept along with a record to the final prices and conditions agreed.

1.17 Where post-tender negotiation is undertaken with some but not all of the companies who submitted tenders a record of criteria for the selection must be kept by the managers concerned. Companies invited to post-tender negotiation must include those in the following categories:

(a) Companies who, following analysis of the original tender offers, are one of the cheapest three for each product item.

(b) The two companies “winning” the highest number total value of business following analysis of the original tender offers.

1.18 In addition to complying with the sections above officers involved in post-tender negotiation should familiarise themselves with the guidance produced by the Central Unit on Purchasing issued by HM Treasury.
(See: www.hm-treasury.gov.uk/pub/html/docs/cup/guidance.html)

1.19 For the period between opening of tenders and completion of the post-tender negotiation the tender documents shall be stored in a secure place when not actively under analysis.

1.20 Consultants appointed by the Board to be responsible for the supervision of a contract on its behalf shall comply with these Standing Financial Instructions as though they were officers of the Board.

1.21 In circumstances where the need for additional work is identified or a variation to an existing contract is required, the Head of Procurement should be consulted first to ensure that this does not represent a material change to the contract which would require a new procurement and tender process. All Variations must be approved by the Director of Finance or designated Deputy, or in their absence, the Chief Executive. Variations shall include not only contract cost but contract term.

1.22 A contract and framework agreement may be modified without a new procurement procedure:

(a) where the modifications, irrespective of their monetary value, have been provided for in the initial procurement documents in clear, precise and unequivocal review clauses, which may include price revision clauses or options, provided that such clauses:

I. state the scope and nature of possible modifications or options as well as the conditions under which they may be used; and

II. do not provide for modifications or options that would alter the overall nature of the contract or framework agreement.

(b) to provide for additional works, supplies or services by the original contractor that have become necessary and were not included in the initial procurement, where a change of contractor:

I. cannot be made for economic or technical reasons such as requirements of interchangeability or interoperability with existing equipment, services or installations procured under the initial procurement; and

II. would cause significant inconvenience or substantial duplication of costs for the contracting authority, provided that any increase in price does not exceed 50% of the initial contract value;

(c) where all of the following conditions are fulfilled:

I. the need for modification has been brought about by circumstances which a diligent contracting authority could not have foreseen;
II. the modification does not alter the overall nature of the contract or framework;

III. any increase in price does not exceed 50 % of the initial contract value or framework agreement.

Guidance within Section 72 of the Public Contracts Regulations 2015 should be followed.

SECTION G

Risk Management

1. Introduction

The Risk Management Strategy sets out the principles and approaches to risk management which are to be followed throughout NHS Forth Valley in relation to risks that could threaten the achievement of business objectives. Its aim is to achieve a consistent and effective application of risk management and enable it to be embedded into all core processes, forming part of the day-today management activity of the organisation. Risk Management, when deployed effectively, should add value by supporting day-to-day activities as opposed to being seen as a separate, self-contained process and this Strategy supports this approach.

1.1. What is a Risk?

A risk can be defined as 'the effect of uncertainty on objectives' (*ISO31000)*. It is essentially any uncertain event which can have an impact upon the achievement of an organisation's objectives – either reducing the likelihood of achievement or stopping it altogether.

Not every perceived problem or adverse event is a risk. An important distinction must be made between what is a risk and what is an issue – or in other words, an uncertainty and a certainty. A risk is an event that may or may not happen. An issue or adverse event is something that is currently happening or has already happened. Issues and adverse events should therefore not be recorded and treated as risks – we want to adopt a proactive rather than reactive stance.

1.2. What is Risk Management?

Risk management is a systematic way of dealing with that uncertainty which involves the identification, analysis, control and monitoring of risk. Risk Management activities are designed to achieve the best possible outcomes and reduce the uncertainty. An effective system of risk management will draw together all types of risks and enable an interrelated view of the organisation's risk profile.

1.3. Why do we need Risk Management?

An effective system of risk management will deliver a range of outputs:

- Ensuring that decision making is informed and risk-based, to maximise the likelihood of achieving key strategic objectives and effective prioritisation of resources
- Ensuring compliance with legislation, regulations, and other mandatory obligations
- Providing assurance to internal and external governance groups that risks are being effectively controlled
- Supporting organisational resilience
- Raising awareness of the need for everyone to adopt consistent risk management behaviours and actions in our everyday business
- Empowering all staff to make sound judgements and decisions concerning the management of risk and risk taking – fostering a "risk aware" rather than "risk averse" culture
- Achievement of effective and efficient processes throughout the organisation

- Anticipating and responding to changing political, environmental, social, technology and legislative requirements and / or opportunities
- Preventing injury and / or harm, damage and losses.

Effective risk management will be achieved by:

- Clearly defining roles, responsibilities and governance arrangements for individuals, teams and assurance committees within NHS Forth Valley
- Incorporating risk management in all Executive Leadership Team, Health Board, Integration
  Joint Board and Assurance Committee reports and when taking decisions
- Maintaining risk registers at all levels that are linked to the organisation's strategic objectives, primarily using risk management software to capture key risk data
- Staff at all levels understanding risk management principles, and consistently applying them through their everyday activities, confidently identifying risks and taking actions to bring them within the organisation's risk appetite
- Monitoring and reviewing risk management arrangements on a regular basis
- Seeking assurance that controls relied on to mitigate risks are effective
- Communication and engagement with stakeholders to maintain awareness, build trust, encourage buy-in and embedding of risk management activities.

2. Risk Architecture

The arrangements for communication, governance, reporting, roles and responsibilities forms the organisation's overarching risk architecture. Defining a consistent approach to how and where risk information is communicated is essential to developing a positive risk culture and to ensuring risk management is appropriately implemented to support NHS Forth Valley activities.
Risks, once identified, are captured on risk registers. Each Department and Specialty will hold a risk register for its area – these form the bottom level of risk registers. There are four main levels of risk register and an escalation route exists for risks that cannot be fully mitigated at the Department / Speciality level. This risk register hierarchy is detailed below.

Risk Register Hierarchy

Strategic Risk Register

Risks contained in the Strategic Risk Register (previously known as the Corporate Risk Register) are the high-level risks that could impact the delivery of longer-term strategic objectives of the organisation. Risks are not escalated/de-escalated from lower-level risk registers to the Strategic Risk Register. Instead, risk identification for the Strategic Risk Register is facilitated through twice yearly review and horizon scanning sessions led by the Executive Leadership Team.

Organisational/System-wide Risk Register

Risks contained in the Organisational/System-wide Risk Register are top level, cross cutting risks that present a significant short-medium term threat to multiple Directorates or the Health and Social Care Partnerships (HSCPs). Risks are escalated and de-escalated via the Directorate and HSCP Risk Register(s).

Directorate Risk Registers

Each Directorate holds a risk register that contains a cut of the most significant risks from its component Departments / Specialties. Risks are escalated to the Directorate level via the individual Department / Specialty risk registers.

Department Risk Registers

Each Department and Specialty will hold a risk register for its area – these form the bottom level of risk registers.

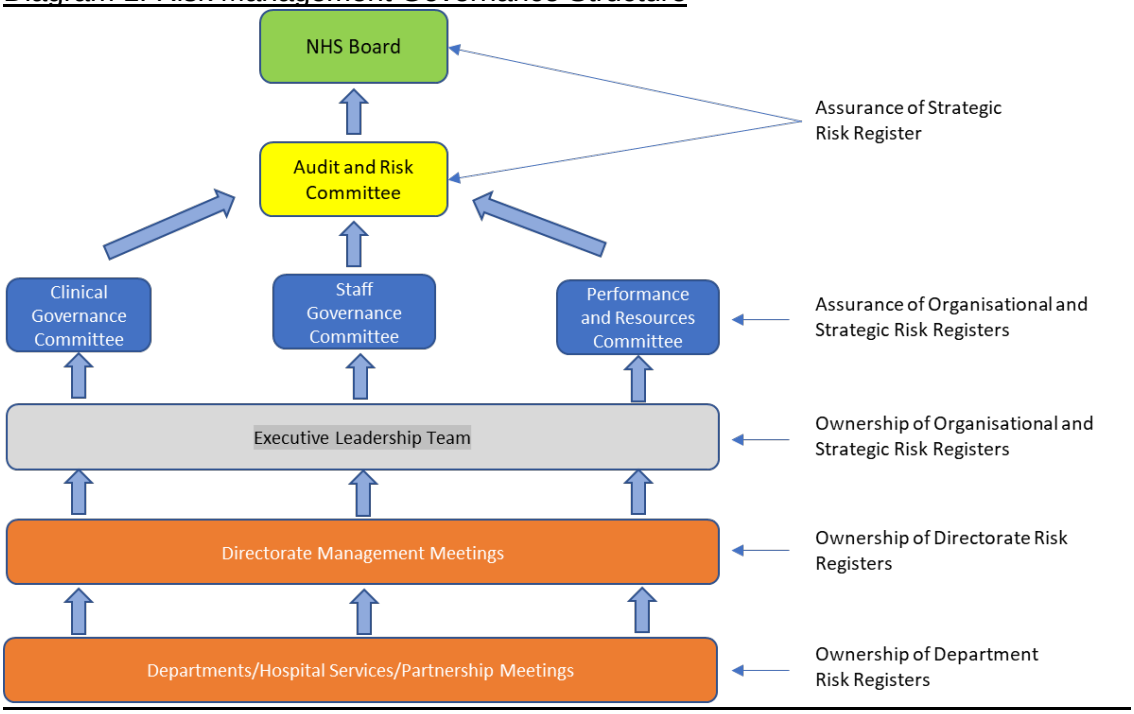
2.1. Governance & Reporting

The Board of NHS Forth Valley is corporately responsible for the Risk Management Strategy and for ensuring that significant risks are adequately controlled. To support

the Board a number of formal committees have been established and are responsible for various aspects of risk management, principally these are the Audit and Risk, Performance & Resources, Clinical Governance and Staff Governance Committees. All Health Board Committees are responsible for providing assurance on the effective management of risks relevant to their area of responsibility. In addition, the Audit and Risk Committee has a responsibility for overseeing the operation of the Risk Management Strategy, taking assurance from the Executive Leadership Team.

Diagram 1 illustrates NHS Forth Valley's risk management governance structure.

Diagram 1: Risk Management Governance Structure


NHS Board
Audit and Risk Committee
Clinical Governance Committee
Staff Governance Committee
Performance and Resources Committee
Executive Leadership Team
Directorate Management Meetings
Departments/Hospital Services/Partnership Meetings
Assurance of Strategic Risk Register
Assurance of Organisational and Strategic Risk Registers
Ownership of Organisational and Strategic Risk Registers
Ownership of Directorate Risk Registers
Ownership of Department Risk Registers

2.2. Roles & Responsibilities

Risk Management Roles & Responsibilities
NHS Board

- Provide Oversight and Scrutiny of NHS Forth Valley's risk management arrangements to seek assurance on their effectiveness

- Approve risk appetite within NHS Forth Valley

Chief Executive

- To have overall accountability for the management of risk across NHS Forth Valley

Executive Leadership Team

- Set risk appetite within NHS Forth Valley
- Ensure risk management processes are supported to provide them with adequate information and assurance related to strategic and organisational/system-wide risks

Audit and Risk Committee

- To evaluate and recommend approval of the strategies and frameworks in respect of risk management to the NHS Board, and provide assurance on the effectiveness of the risk management arrangements, systems and processes
- To approve updates and provide direction in respect of risks held within the strategic and organisational/system-wide risk registers
- To review the organisation's risk culture and maturity and direct action in pursuit of continuous improvement in this area
- To formally approve the strategic risk register for onward reporting to the NHS Board

Assurance Committees

- To ensure that an appropriate approach is in place to deal with risk management across the system working within the NHS Forth Valley Risk Management Strategy, and consider and endorse the assurance provided by the Executive Leadership Team and Senior Management regarding the effective management and escalation of risks

Executive and Non Executive Directors

- To ensure that risk management processes are providing appropriate information and assurances relating to risks in Directorates
- Promote the importance of risk management and foster a good risk culture within their area of responsibility
- Approve escalation of Directorate level risks where appropriate

Corporate Risk Manager

- Responsible for the implementation of the Risk Management Strategy
- Ensure risks are properly identified, understood and managed across all levels within the organisation
- Report on the organisation's risk profile at Assurance and Audit Committees and NHS Board, and oversee reporting to Directorates
- Periodically review the Risk Management Strategy and arrangements, identifying areas for potential improvement
- Drive an improving risk culture through risk education, awareness and embedding into day-today management

- Assist the Corporate Risk Manager with the development and implementation of the Risk Management Strategy
- Act as a key point of contact for Risk Management, providing expert advice and guidance and supporting the Directorates and Partnerships
- Assist the Corporate Risk Manager with reporting on the organisation's risk profile, providing Risk Management representation at various levels
- Support an improving risk culture through delivery of training, awareness and supporting

Directorates and Partnerships to embed risk considerations into day-to-day management

Risk Owner

- Accountable for ensuring the effective management of a risk, and providing assurance that key controls are operating effectively
- While the Chief Executive owns all risks, ownership and therefore accountability is delegated to an appropriate level
- At Strategic and Organisational/system-wide Level, the risk owner is the relevant Director/Chief Officer
- At Directorate and Departmental Level the risk owner is the relevant Head of Service/Department or equivalent

Risk Lead

- Responsible for managing a risk on a day-to-day basis, assessing the risk score and updating the management plan, reviewing the risk on a regular basis and identifying sources and levels of assurance regarding control effectiveness, to allow risk owners to provide assurance

Risk Champion

- Responsible within an individual speciality, department or Directorate area for maintaining lines of communication with the risk function, administering the risk register and co-ordinating all risk activities

Integrated Risk Management: Health & Social Care Partnerships

In order to ensure strong risk management partnership arrangements, it will be necessary to agree how some emerging risks have an impact on more than one partner at a strategic level. Risks will be discussed and agreed across partners, with particular focus on:

- Where the risk was first identified
- Date of identification
- Nature of emerging risk
- Impact areas (e.g. service delivery, performance, strategic commissioning intentions etc)
- Mitigation required
-

Risks with the potential to impact more than one partner will be identified for inclusion in one or more of the following risk registers:

- NHS Forth Valley Strategic Risk Register or Organisational/System-wide Risk Register
- Clackmannanshire and Stirling IJB Strategic Risk Register
- Falkirk IJB Strategic Risk Register
-

Any such emerging risks will be submitted to the NHS Forth Valley Executive Leadership Team to approve inclusion on the Strategic Risk Register.

Operational risks will continue to be managed by partner bodies, with relevant risk specialists working together to ensure consistent practice, and that respective Risk Management strategies are aligned. The IJBs will also have a defined risk appetite to determine the target score range for strategic risks. It is recognised that partners may not have the same appetite, however these variances will be taken into consideration when the risks are being managed and reported.

Reciprocal assurances on the operation of the Risk Management arrangements and of the adequacy and effectiveness of key controls will be provided to/from partners. Receipt/provision of assurance will be facilitated by risk specialists from partner bodies, who will attend regular meetings to discuss risks and provide relevant advice.

3. Risk Appetite

Utilising risk appetite principles can help the organisation identify and set appropriate thresholds for risks, whereby the Board establishes the level of risk they are willing and able to absorb in pursuit of objectives.
The delivery of public services can be inherently high risk and the concept of applying risk appetite can be challenging. However, the application of risk appetite, particularly in a resource-finite environment, is essential to avoid over or under management of risk. Deployed effectively, risk appetite can act as an enabler to the delivery of key services.

Risk Appetite:
The amount and type of risk we, as an organisation, are willing to seek or accept in the pursuit of our objectives.

Key considerations when applying risk appetite:

- It is not always possible to manage every risk down the minimum or most desirable level and maintain service delivery
- It is not always financially affordable or manageable to fully remove risk and uncertainty from decision making and service delivery
- Risk management is concerned with balancing risk and opportunity (or downside risk and upside risk)

When a risk increases to a point where it is no longer within risk appetite, it may initially fall within a range which is not desirable, but the organisation has the capacity to tolerate. This is known as the risk tolerance range.

Risk Tolerance:
The maximum level of risk the organisation can tolerate regarding each type of risk before it is significantly impacted.

If a risk is out of appetite and falls within the tolerance range, this indicates that close monitoring and corrective action is required to bring the risk back within appetite. A risk with a current score out with the tolerance range requires escalation and immediate corrective action.

There are benefits to the practical application of Risk Appetite:

- supports decision making (resources can be allocated to risks further away from the desired appetite level)
- allows further prioritisation (if you have several risks with the same score, mitigate those further from appetite first)
- subjectivity is taken away from the setting of target scores (the appetite range becomes the target score)

Risk appetite is also useful when budget setting or considering approval of business cases, such as those relating to innovation activity. Identifying associated risks and their appetite levels allows focus on activities which mitigate the risks furthest from the organisation's desired risk appetite/tolerance levels.

3.1. Risk Appetite Levels

There are four levels of risk appetite within NHS Forth Valley. Each risk category in the risk assessment matrix is assigned one of the risk appetite levels described below. The risk appetite levels and their application to each risk category is set and approved by the NHS Board. Risk appetite may vary depending on internal and external circumstances; therefore the levels will be reviewed on an annual basis.

Averse:
- Very little appetite for this type of risk
- Avoidance of risk and uncertainty is a key organisational objective
- Exceptional circumstances are required for any acceptance of risk

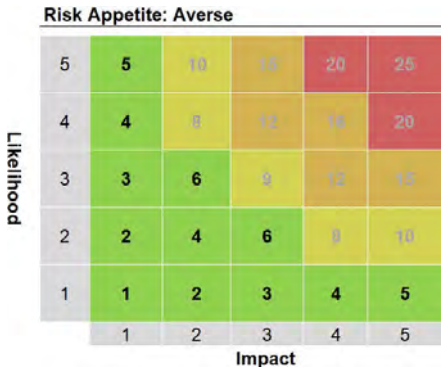
Cautious:
- Minimal appetite for this type of risk.
- Preference for ultra-safe delivery options that have a low degree of inherent risk and only reward limited potential.

Moderate:
- Acceptance that a level of risk will be required to pursue objectives, or that a greater level of risk must be tolerated in this area.
- Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential reward.

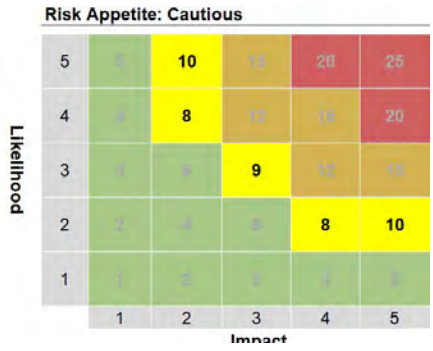
Open:
- Acceptance that risk must be more actively taken in the pursuit of transformation or that a high level of risk must be tolerated.

- Willing to consider all potential delivery options and choose the one most likely to result in successful delivery while also providing an acceptable level of reward (and Value for Money).
- Eager to be innovative and confident in setting high level of risk appetite as controls are robust.

Each risk appetite level correlates with risk score levels on our risk assessment matrix as shown below. Refer to the NHS Forth Valley Risk Appetite Statements (Appendix E) for details on risk appetite levels for each risk category.

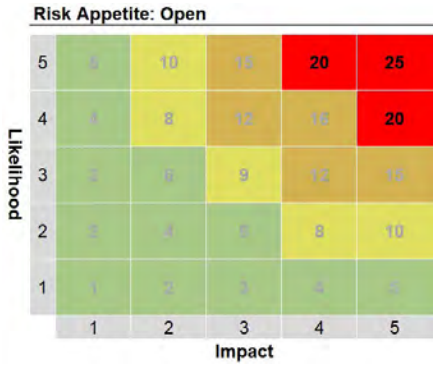


Demonstrates that if the risk appetite is 'Averse', a risk score of between 1-6 and the range of associated outcomes is within appetite



Demonstrates that if the risk appetite is 'Cautious', a risk score of between 8-10 and the range of associated outcomes is within appetite

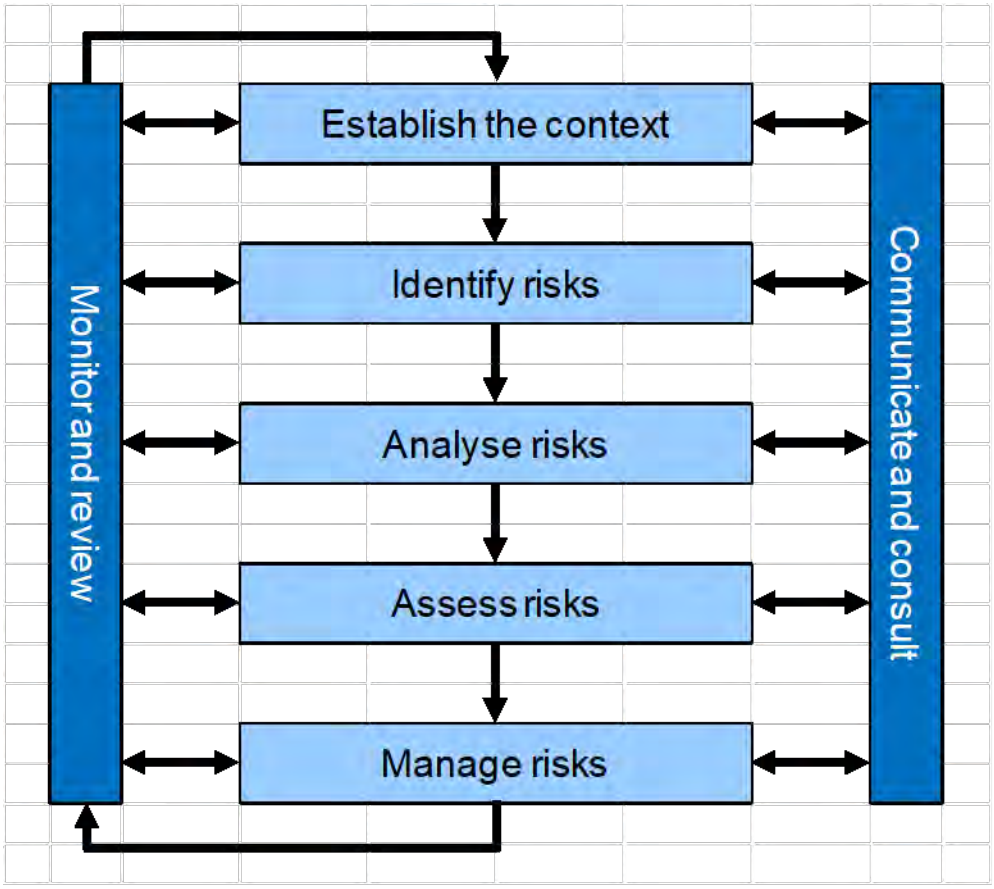
Demonstrates that if the risk appetite is 'Moderate', a risk score of between 12-16 and the range of associated outcomes is within appetite



Demonstrates that if the risk appetite is 'Open', a risk score of between 20-25 and the range of associated outcomes is within appetite

4. Approach to Risk Management

4.1. Risk Management Process – ISO31000



The above diagram demonstrates the whole process and cycle of risk management under the international standard ISO 31000.

The standard as outlined above makes clear that risk management is a dynamic process, with frequent review of existing risks and monitoring of the environment necessary to ensure the risks captured represent the current profile of the organisation.

Continual communication of risks within the organisation is essential to allow for informed decisionmaking. Communication to the Health Board and other stakeholders is also imperative to allow effective scrutiny and provide assurance that our risk profile is being effectively managed. It is also imperative to consult with and receive information from other departments within the organisation and our stakeholders to inform the management of our risks.

4.2. Step 1: Establish Context

The purpose of establishing context is to customise the risk management process, enabling effective risk analysis and appropriate risk treatment. In order to identify risks, we need to understand what we are assessing risk *against.* We must set risks within the context of the team, specialty, department and overall organisation. In addition, we need to recognise the internal and external drivers that could create risk.

Risks should be set against what we are trying to achieve as an organisation – our strategic objectives. In this stage it is important to ensure there is a common understanding of what those objectives mean at a team, specialty, department and organisational level in order that risk identification is not based on an inconsistent set of assumptions.

4.3. Step 2: Identify Risks

Once a clear, common set of objectives are agreed, the next step of the process is to identify potential risks that will prevent us from achieving them.

A range of techniques can be used for risk identification. Some prompts to consider:

- What might impact on your ability to deliver your objectives?
- What does our performance data tell you?
- What do our audit and scrutiny reports and external reviews tell us?
- Do you have experience in this area? Do you know or do you need to involve others?
- Should you involve partners or specialists in your risk identification?
- Lessons learned – what happened before?

Risk can be identified in a multitude of ways, through focused identification sessions or as a product of other work:

Focused Identification Methods	Other Identification Opportunities

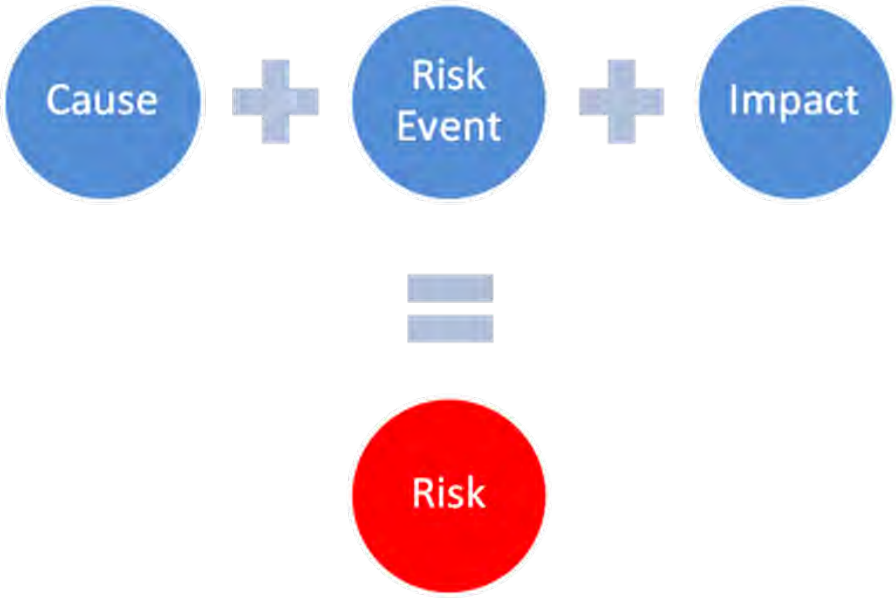
• Risk Identification Workshops • Risk Questionnaires • Review & refresh of existing risk registers • Interviews	• Horizon scanning • Board meetings / working groups / management meetings • Audit & scrutiny reports • Performance data • Risk Management training

The Risk Management function facilitates risk identification workshops with Departments to direct an in-depth review of new or emerging risks.

It is important to note that just because a risk cannot be fully mitigated by the organisation alone does not mean that it should not be captured. If the risk exists to the organisation, then it should be captured, managed as far as practicable and then monitored. Ongoing management of the risk may well be in conjunction with partner agencies or influence can be exerted over those capable of mitigating the risk to within an acceptable level.

4.4. Step 3: Analyse Risks

Once a risk has been identified it must be described in a certain way in order to effectively understand, manage and mitigate it. The risk description should contain three essential components:



These three components can be included within the description as follows:

"If [insert cause here], there is a risk that

[a certain event that may happen], resulting in

[describe impact this will have if it manifests]"

An example of an effective risk description might be:

If there is insufficient in external funding and continued uncertainty over our cost base there is a risk that NHS FV will be unable to achieve financial sustainability, resulting in Scottish Government intervention and a detrimental impact on service delivery.

Without understanding the underlying causes of the risk and all the potential impacts, it would be very difficult to design and implement effective controls.

4.5. Step 4: Assess Risks

The assessment, or scoring, of risk allows for prioritisation by severity. Determining the likelihood and impact of a risk and utilising a standardised assessment criteria to assign a score based on these factors allows us to understand and prioritise which risks to mitigate first. Three scores must be assigned to cover the full trajectory and lifespan of the risk:

Untreated Score

This is the inherent risk score, that is the score with no controls applied. This score represents the "reasonable worst case scenario" for the risk. If there were no controls, mitigation or contingency plans in place, how likely is it the risk would materialise and what would the impact be?

Current Score

Considering any controls that are currently in place to manage the risk, how does the risk score compare to the untreated score? This is the current score. Current risk score is assessed on a regular basis to establish the effectiveness of the controls applied to the risk. It is also the current score that is the key indicator used to determine if the risk should be considered for escalation.

Target Score

The target risk score is the optimum position for the risk. Once all controls have been adequately implemented, what will the residual risk score be? Target risk scores should reflect the organisation's risk appetite and align with the amount and type of risk NHS Forth Valley is willing to accept (refer to section 3 on Risk Appetite). Risk controls should be designed to actively reduce the risk score towards the target level.

Risk Assessment Matrix

The risk assessment matrix is a 5x5 scoring mechanism which will identify a score between 1 (1x1) at the lowest and 25 (5x5) at the highest possible score.

When utilising the impact criteria on the assessment matrix, a score must be applied for every category of impact applicable to that risk. For example, one risk may have a financial impact, an impact to patient experience and public confidence implications. The impact category with the highest scoring criteria will identify the overall impact score for that risk.

Assessment of likelihood is considered on a sliding scale from 1 to 5, with 1 representing 'very unlikely' and 5 'very likely.'

Once both scores have been identified, they are multiplied giving the overall score at *untreated, current* and *target* levels.

A full copy of the Risk Assessment matrix is included at Appendix B.

Categorisation

All risks, once identified, must be categorised into one of the recognised impact categories in order to understand the overall risk profile for the organisation. Categorisation of a risk is based upon the impact score, with the impact category which has the highest scoring criteria for that particular risk determining the risk category.

For example, a risk scoring a 3 for impact in Patient Experience but scoring a 5 in Finance will categorise that risk as Finance overall. Risk categories are outlined in the risk assessment matrix:

- Patient Harm
- Patient Experience
- Transformation/Innovation
- Health and Safety
- Service Delivery / Business interruption
- Workforce
- Financial
- Inspection / audit
- Public Confidence
- Health Inequalities
- Environmental Sustainability / Climate Change

Where more than one category has the same impact score, select the category which has the lower risk appetite level. For example, if Patient Experience and Finance both score 5, but Patient Experience has an averse appetite but Finance has a cautious appetite, select Patient Experience. If both categories have the same risk appetite level, use professional judgement (see Appendix D for current levels).

4.6. Risk Escalation/De-escalation

Risk escalation is a process that ensures significant risks that cannot be managed by a local team, department or specialty are escalated appropriately following the risk register hierarchy and line management arrangements. Risks are escalated in accordance with the agreed risk appetite and tolerance for that category of risk.

If a current risk score is above the agreed risk appetite for that risk category and falls into the tolerance range, the departmental/service management or equivalent should closely monitor the risk and undertake corrective action by amending existing controls or applying new controls. If the risk remains in tolerance after 6 months, the risk should be escalated to Directorate level for oversight and direction of mitigating action.

If a current score exceeds both appetite *and* tolerance, it should be escalated to Directorate level straight away for enhanced oversight and direction of action.

The risk appetite and tolerance levels (escalation criteria) are set out in Appendix D.

At Directorate level, consideration can be given as to whether further escalation to the Organisational/System-wide Risk Register is required, meaning additional scrutiny and direction of action by the Executive Leadership team as a collective, and reporting to the standing assurance committees.
The following questions should be asked when deciding whether to further escalate a risk to the Organisational/system-wide risk register:

- Does the risk have a widespread impact beyond a local area, e.g. does it affect multiple Departments, Directorates or HSCPs, or does it have dependencies on multiple Departments, Directorates or HSCPs to mitigate?
- Does the risk present a significant cost/decision making beyond the scope of the budget holder, or require change driven at an organisational/system-wide level?

Risks can be de-escalated to the appropriate level (Directorate or Departmental) once back within risk appetite.

4.7. Step 5: Manage Risks

The purpose of this step is to select and implement the appropriate action to respond to the risk. There are four broad ways we can respond to risk, known as the 4 Ts:

- Tolerate: this is the decision to accept the risk at its current level (usually after treatment). The ability to do anything may be limited, or the cost of taking action may be disproportionate to the benefit gained. Generally, it is risks that are within appetite that are tolerated.
- Treat: this is the decision to retain the activity or process creating the risk and to take action to implement risk controls that reduce either the likelihood of the risk occurring or minimising the impact. Risks which are out of appetite or tolerance will have to be treated.
- Transfer: this is the decision to transfer the impact of the risk either in full, or in part, to a third party. The most common form of risk transfer is insurance.
- Terminate: this is the decision to stop doing the activity associated with the risk. This may not always be possible and may create risks elsewhere as a result.

Risk Controls

Risk controls are management measures put in place to effectively manage a risk to within acceptable levels (i.e. to target score range). It is essential that the controls put in place to manage a risk are effective. The identification of effective controls is the most important part of the whole risk management process as without this element we would simply be identifying risks and doing nothing to manage them.

To assess whether the controls we identify are or will be effective, it is important to consider the following:

- What do you already have in place to manage the cause and / or impact of the risk? e.g. policies, procedures, projects, training courses, business continuity plans etc
- Do they work and what evidence do you have of the effectiveness? A policy which is in place but never complied with is not an effective one.
- Are there any gaps in your controls?

- Do you have all the information that you need about this risk or do you need to find out more?
- What more should you do?
- If several activities are required to manage the risk, how will you prioritise these?
- Are these controls within the remit of your department? If not, you will need to liaise with stakeholders to ensure that appropriate controls are put in place.
- If you implement the controls you have identified, will this manage the risk to within acceptable levels for that risk category? If the answer is no, further controls are required.

There are two main types of control measure that can be put in place to manage a risk:

- *Preventative Controls:* These are mitigating actions which will work to control the cause of the risk and prevent it happening in the first place.
- *Contingency Controls:* These are actions that can be put in place to reduce the impact of the risk if it does materialise. Contingency controls are often aligned to the business continuity plans of an organisation.

As an example, consider fire safety measures. Segregation of flammable materials and sources of ignition is a control which prevents the risk of fire. Smoke detectors, sprinkler systems and fire evacuation plans are contingency controls should the risk of fire materialise.

If a risk has been effectively analysed (see section 4.4), it will be much easier to identify appropriate preventative and/or contingency controls.

4.8. Monitor and Review

Risk Review

Once the process of identifying, analysing and assessing a risk are complete, it is imperative that it is subject to regular review. Ongoing management and review of a risk is the most important part of the process, as maintaining or reducing the risk score to within an acceptable range assures the overall management of the organisation's risk profile.

Required risk review timescales are outlined below:

Out of Tolerance	Monthly
In Tolerance	Every 2 months
In Appetite	Every 6 months

These are the minimum review timescales – if there are changes in the operating environment which could affect the severity of a risk, it can be reviewed and reported more frequently.

During a risk review, the risk score must be re-assessed. If it is identified that the risk continues to exist, the list of current controls and further controls required must be checked and added to where necessary. On the basis of progress with controls and

an assessment of the risk environment (i.e. are there any significant changes to the internal/external context), a re-assessment of the current score must be made using the risk assessment matrix. This will show whether the risk is decreasing, increasing or remaining static, and whether or not the risk requires escalation. Depending on its escalation level, a change to risk score will be reported at the appropriate assurance committee.

Review of the Risk Management Process

In addition to review of the risks themselves, the Risk Management team also reviews the whole system of risk management – are the right risks being escalated at the right time? Are the tools we provide sufficient to allow staff to effectively identify, analyse, assess and manage their risks? This enables learning and improvement and ensures that risk management adds value to the organisation's activities.

Assurance

A fundamental component of any risk management framework is the expert and objective assessment of risk controls to ensure they are well designed and operate effectively. Implementing a process to critically review risk controls provides the Board with assurance on the effective management of key strategic risks. To facilitate the provision of assurance, NHS Forth Valley utilises the "three lines of defence" model.

Operating as the first line, operational management has ownership, responsibility and accountability for directly assessing, controlling and mitigating risks, understanding what the key controls are, and how effectively and consistently those controls are operating, in order to provide assurance to the Board. The second line is provided by governance/compliance functions such as Risk Management, who will assist the first line in developing an approach to fulfilling their assurance responsibilities. Internal Audit forms the third line, (providing independent assurance, and checking that the risk management process and framework are effective and efficient).

The levels of assurance and associated system and control descriptors are shown below:

Overall Risk Assurance Assessment		
Level of Assurance	**System Adequacy**	**Controls**
Substantial Assurance	Robust framework of key controls ensure objectives are likely to be achieved.	Controls are applied continuously or with only minor lapses
Reasonable Assurance	Adequate framework of key controls with minor weaknesses present.	Controls are applied frequently but with evidence of non-compliance

Limited Assurance	Satisfactory framework of key controls but with significant weaknesses evident which are likely to undermine the achievement of objectives.	Controls are applied but with some significant lapses
No Assurance	High risk of objectives not being achieved due to the absence of key internal controls.	Significant breakdown in the application of controls

Assurance should be provided to the relevant committees for their consideration on an ongoing basis. Any papers submitted as a source of assurance for the committee should explicitly reference the related strategic risk and should provide a conclusion as to whether performance indicates that controls are operating effectively and as intended. At the start of the year, assurance mapping principles will be used to determine the assurance requirements, and this will be set out in the committee assurance workplan. Assurance provision over the course of the financial year will be tracked and managed utilising the Pentana system.

Risks on the strategic risk register are subject to a rolling programme of 'deep dives' considered by the relevant assurance committee. Deep dive reviews are facilitated by the Risk Owner/Lead and Corporate Risk Manager and provide expert, objective assessment of the following key areas:

- Comparison of current risk score and target risk score
- Requirements to achieve the target risk score – success criteria for managing the risk
- Assessing the importance and effectiveness of implemented controls
- Assessing the proportionality of further controls required – i.e. will they help to achieve target score?
- Reviewing the assurance activity aligned to the risk controls in order to establish an overall assurance statement for the risk
-

Refer to Appendix C for guidance on risk controls assurance.

4.9. Communicate and Consult

Communication at all levels is important to allow for informed decision making, and provision of assurance that our risk profile is effectively managed – this is achieved through risk reporting.

Risk Reporting

A quarterly risk management report is presented to the Health Board which reports on our strategic risks. In addition, Assurance Committees are provided with a regular risk management report on strategic and organisational/system-wide risks assigned to their area of scrutiny.
The Executive Leadership Team acts as the Risk Management Steering Group and provides recommendations to the Board on the status of strategic level risks. Directorates and Departments are expected to carry out regular review, monitoring and

reporting on their risk registers (supported by the risk management function) to ensure that risks are identified and escalated to the appropriate level at an early stage.

The risk management reporting in place includes a range of risk management KPIs and trend analysis that enhances oversight and assurance for the Health Board. An annual report on risk management is also produced for the Health Board.

The Health and Social Care Integration Schemes for both Falkirk Integration Joint Board (IJB) and Clackmannanshire and Stirling IJB, detail the requirements and responsibilities regarding Risk Management for the IJBs and constituent parties. The IJBs will establish a Risk Management Strategy including a risk monitoring framework. Risks to delegated services which are identified will require to be communicated across partner organisations with clear responsibilities, ownership and timescales, and with mechanisms to ensure that assurance can be provided to the relevant Boards. Risk specialists from all parties will work together to ensure that Risk Management strategies are aligned to facilitate effective escalation of risks and provision of assurance.

5. Training, Learning and Development

A key part of developing a positive risk management culture in support of improving the overall risk maturity is the delivery of risk management training.

There are two levels of training available to staff within NHS Forth Valley and the two Health and
Social Care Partnerships. The first level is an online module hosted on TURAS, “Introduction to Corporate Risk Management”, and is aimed at all staff within the organisation/partnerships.

The second level is the “NHS Forth Valley Corporate Risk Management Training”, aimed at staff who have specific responsibilities involving the management of risk within their service areas, for example Risk Champions and Risk Leads. The course enhances knowledge and understanding of corporate risk management methodology and processes used within the NHS Forth Valley and the partnerships.

Eligibility for Level 2 training can be confirmed by contacting the mailbox at fv.corporateriskmanagement@nhs.scot

6. APPENDIX A: GLOSSARY

Assurance. Stakeholder confidence in our service gained from evidence showing that risk is well managed, achieved by risk owners and leads confirming that significant risks are being adequately managed, that critical controls have been identified, implemented and are effective.

Contingency. An action or arrangement that can be implemented to minimise impact and ensure continuity of service when things go wrong.

Current Risk Score: The risk score identified taking into account any controls that are currently in place to manage the risk.

Governance. The system by which organisations are directed and controlled to achieve objectives and meet the necessary standards of accountability, probity and openness in all areas of governance.

Internal Control. Corporate governance arrangements designed to manage the risk of failure to meet objectives.

Issue: Something that has happened and is currently affecting the organisation in some way and needs to be actively dealt with and resolved.

Likelihood. Used as a general description of probability or frequency which can be expressed quantitatively or qualitatively.

Risk: An uncertain event, or set of events, which, should it occur, will have an effect on the organisation's ability to achieve its objectives.

Risk Appetite. The level of risk that an organisation is prepared to accept in pursuit of its objectives.

Risk Architecture: All of the Risk Management arrangements within an organisation – sets out lines of communication and reporting, delegation and roles / responsibilities.

Risk Assessment. The scoring of a risk to allow prioritisation. Determining the likelihood and impact of a risk.

Risk Champion: The person / role with responsibility within an individual department or business area for maintaining lines of communication with the Risk Management team, administering the risk register and co-ordinating all risk activities.

Risk Control: Management measures put in place to effectively manage a risk to within an acceptable level. Can be preventative or contingency in nature and will reduce the likelihood or impact of consequence.

Risk Culture: The reflection of the overall attitude of every part of management of an organisation towards risk.

Risk Target Score: An acceptable level of risk based on the category of risk and risk appetite.

Risk Escalation. The process of delegating upward, ultimately to the Board, responsibility for the management of a risk deemed to be impossible or impractical to manage locally.

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Risk Lead: The person / role responsible for managing a risk on a day-to-day basis, assessing the risk score and updating the management plan, reviewing the risk on a regular basis.

Risk Management: The integrated approach (culture, processes, structures) to the identification, analysis, control and monitoring of risk.

Risk Management Policy: Statement outlining the objectives of the risk management practices within the organisation.

Risk Management Strategy**:** Sets out the basis for the principles, processes and approaches to risk management to be followed in order to achieve a consistent and effective application of risk management and allow it to be embedded into all core processes.

Risk Matrix: A scoring mechanism used to identify the severity of a risk, using a multiplication of likelihood and impact, across pre-set categories.

Risk Maturity: The level of risk management capability within an organisation.

Risk Owner: The person / role with accountability for ensuring the effective management of a risk

Risk Register: A tool used to capture and monitor risks. Includes all information required about that particular risk and is intended to be used both as a management tool and conduit for risk reporting.

Risk Tolerance. The maximum level of risk the organisation can tolerate regarding each type of risk before the organisation is significantly impacted.

Threat: A negative scenario which could give rise to risks.

Untreated Risk Score: The risk score identified by assessing the risk with no controls, mitigation or contingency plans in place.

7. APPENDIX B: RISK ASSESSMENT MATRIX

Impact – What could happen if the risk occurred?

Assess for each category and use the highest score identified.

Category	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Patient Harm *(through delivery or omission of care, risk results in unintended/unexpected but avoidable physical or psychological harm to a patient)*	Adverse event Negligible effect on patient	Minor episode of harm not requiring intervention	Harm which requires intervention but doesn't trigger organisational Duty of Candour response	Harm, such as sensory, motor, or intellectual impairment which has lasted or is likely to last at least 28 days OR Pain or psychological harm which lasts, or is likely to last, at least 28 days And triggers organisational Duty of Candour	Severe harm such as death or permanent disability, either physical or psychological (e.g., removal of wrong limb/organ or brain damage) And triggers organisational Duty of Candour

Patient Experience *(risk could impact on how a patient, their family or carer feels during the process of receiving care)*	Reduced quality patient experience Locally resolved verbal complaint or observations	Unsatisfactory patient experience directly related to care provision – readily resolvable Justified written complaint peripheral to clinical care	Unsatisfactory patient experience/clinical outcome with potential for short term effects Justified written complaint involving lack of appropriate care Themes emerging – readily or locally resolvable	Unsatisfactory patient experience /clinical outcome with potential for long-term effects Multiple justified complaints Serious problem themes emerging, informed from more than one source	Unsatisfactory patient experience/clinical outcome, continued ongoing long term effects Complex Justified complaints Confirmed serious problem themes from more than one source Involvement of Scottish Public Services Ombudsman
Transformation/Innovation *(risk could impact on ability to successfully adapt and transform)*	Barely noticeable reduction in scope/quality/ schedule Negligible impact on achievement of intended benefits	Minor reduction in scope/quality/ schedule Minor impact on achievement of intended benefits	Reduction in scope/quality/project/programme objectives or schedule Some intended benefits will not be achieved	Significant project/programme over-run Significant proportion of intended benefits will not be achieved	Failure to deliver project/programme Failure to achieve sustainable transformation
Health and Safety *(risk could impact on staff/public, or a patient out with delivery of care)*	Adverse event leading to minor injury not requiring first aid No staff absence	Minor injury or illness, first aid treatment required Up to 3 days staff absence	Agency reportable, e.g., Police (violent and aggressive acts) Significant injury requiring medical treatment and/or counselling RIDDOR over 7- day absence due to injury/dangerous	Major injuries/long term incapacity /disability (e.g., loss of limb), requiring, medical treatment and/or counselling RIDDOR over 7- day absence due to major injury/dangerous occurrences.	Incident leading to death(s) or major permanent incapacity RIDDOR Reportable/FAI

			occurrences		

Service Delivery/ Business Interruption *(risk could impact on ability to efficiently and effectively deliver services)*	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service	Short term disruption to service with minor impact on patient care/ quality of service provision	Some disruption in service with unacceptable impact on patient care Resources stretched Prolonged pressure on service provision	Sustained loss of service which has serious impact on delivery of patient care Contingency Plans invoked Temporary service closure	Permanent loss of core service/ facility Major Contingency Plans invoked Disruption to facility leading to significant "knock on" effect Inability to function as an organisation
Workforce *(risk could impact on staff wellbeing, staffing levels and competency)*	Negligible impact on staff wellbeing Temporary reduction in staffing levels/skills mix Individual training/competency issues	Minor impact on wellbeing, requires peer support Short-term reduction in staffing levels/skills mix (<6 months) Small number of staff unable to carry out training or maintain competency levels Increased usage of supplementary staff	Moderate impact on staff wellbeing, requires line manager support Medium-term reduction in staffing levels/skills mix (>6 months) Moderate number of staff unable to carry out training or maintain competency levels Reliance on supplementary staff in some areas	Serious impact on staff wellbeing, requires referral to support services Long-term reduction in staffing levels/skills mix (>9 months) Significant number of staff unable to carry out training or maintain competency levels Reliance on supplementary staff in multiple areas	Critical impact on staff wellbeing, co-ordinated response and referral to support services Loss of key/high volumes of staff Critical training and competency issues throughout the organisation Unsustainable reliance on supplementary staff across organisation.

Financial *(risk could impact through unplanned cost/reduced income/loss/non-achievement of intended benefit of investment)*	Some adverse financial impact but not sufficient to affect the ability of the service /department to operate within its annual budget	Adverse financial impact affecting the ability of **one or more** services/ departments to operate within their annual budget	Significant adverse financial impact affecting the ability of **one or more** directorates to operate within their annual budget	Significant adverse financial impact affecting the ability of the organisation to achieve its annual financial control total	Significant aggregated financial impact affecting the long-term financial sustainability of the organisation
Inspection/Audit *(risk could impact on outcome during/after inspection by internal/external scrutiny bodies)*	Small number of recommendations which focus on minor quality improvement issues	Recommendations made which can be addressed by low level of management action	Challenging recommendations that can be addressed with appropriate action plan	Mandatory improvement required. Low rating. Critical report. High level action plan is necessary	Threat of prosecution. Very low rating. Severely critical report. Board level action plan required
Public Confidence *(risk could impact on public/stakeholder trust and confidence, and affect organisation's reputation)*	Some discussion but no impact on public confidence No formal complaints or concerns	Some concerns from individuals, local community groups and media – shortterm Some impact on public confidence Minor impact public perception and confidence in the organisation	Ongoing concerns raised by individuals, local media, local communities, and their representatives - long-term Significant effect on public perception of the organisation	Concerns raised by national organisations/scrutiny bodies and short-term national media coverage Public confidence in the organisation undermined Use of services affected	Prolonged national/international concerns and media coverage Issues raised in parliament Legal Action/ /Public Enquiry/FAI/Formal Investigations Critical impact on staff, public and stakeholder confidence in the organisation
Health Inequalities **(***risk could increase health inequalities, particularly those that are healthcare generated)*	Negligible impact on health inequalities such as morbidity/mortality and healthy life expectancy No impact on services	Minor impact on health inequalities such as morbidity/mortality and healthy life expectancy Some services experience increased pressures	Moderate impact on health inequalities such as morbidity/mortality and healthy life expectancy Causes short term increased pressures across the system	Serious exacerbation of health inequalities such as morbidity/mortality and healthy life expectancy Causes long term pressures in system/affects ongoing viability of a service	Critical exacerbation of health inequalities such as morbidity/mortality and healthy life expectancy Affects whole system stability/sustainability

Environmental Sustainability / Climate Change *(risk could impact on environment, ability to comply with legislation/targets or environmentally sustainable care)*	Limited damage to environment, to a minimal area of low significance Negligible impact on ability to comply with climate legislation/targets or ability to reach net zero Negligible impact on ability to provide environmentally sustainable care	Minor effects on biological or physical environment Minor impact on ability to comply with climate legislation/targets or ability to reach net zero Minor impact on ability to provide environmentally sustainable care	Moderate short-term effects but not affecting eco-system Moderate impact on ability to comply with climate legislation/targets or ability to reach net zero Moderate impact on ability to provide environmentally sustainable care	Serious medium term environmental effects Serious impact on ability to comply with climate legislation/targets or ability to reach net zero Serious impact on ability to provide environmentally sustainable care	Very serious long term environmental impairment of eco-system Critical non-compliance with climate legislation/targets or ability to reach net zero Critical impact on ability to provide environmentally sustainable care

Likelihood – What is the likelihood of the risk occurring? Assess using the criteria below.

Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
It is assessed that the risk is very unlikely to ever happen.	**It is assessed that the risk is not likely to happen.**	**It is assessed that the risk may happen.**	**It is assessed that the risk is likely to happen.**	**It is assessed that the risk is very likely to happen.**
Will only occur in exceptional circumstances	**Unlikely to occur but potential exists**	**Reasonable chance of occurring - has happened before on occasions**	**Likely to occur - strong possibility**	**The event will occur in most circumstances**

Risk Assessment Table – Multiply likelihood score by impact score to determine the risk rating (score).

	5	Low 5	Medium 10	High 15	Very High 20	Very High 25

LIKELIHOOD						
	4	Low 4	Medium 8	High 12	High 16	Very High 20
	3	Low 3	Low 6	Medium 9	High 12	High 15
	2	Low 2	Low 4	Low 6	Medium 8	Medium 10
	1	Low 1	Low 2	Low 3	Low 4	Low 5
		1	2	3	4	5
		IMPACT				

8. APPENDIX C: RISK CONTROLS ASSURANCE GUIDANCE – NHS Forth Valley

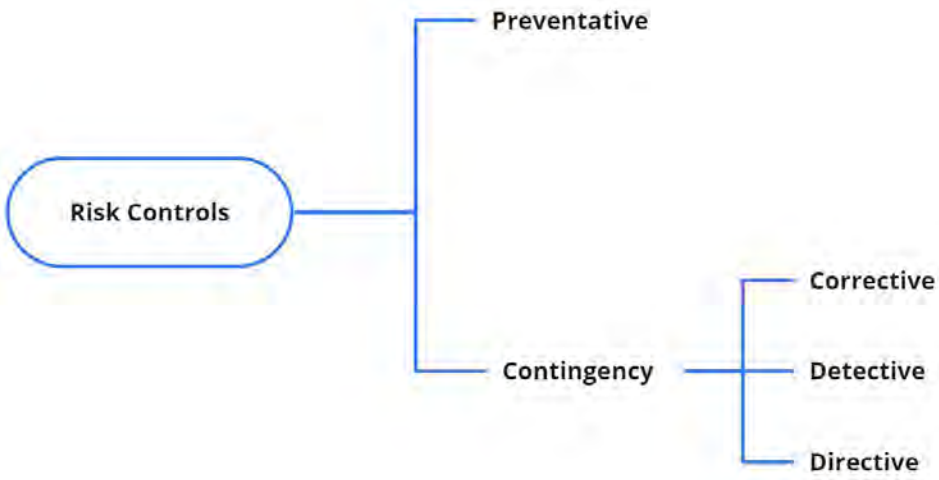
Risk Controls Assurance Guidance – NHS Forth Valley

Overall Risk Assurance Assessment		
Level of Assurance	**System Adequacy**	**Controls**
Substantial Assurance	A sound system of governance, risk management and control, with internal controls operating effectively and being consistently applied to support the achievement of objectives.	Controls are applied continuously or with only minor lapses

Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, noncompliance or scope for improvement identified which may put at risk the achievement of objectives.	Controls are applied frequently but with evidence of non-compliance
Limited Assurance	Significant gaps, weaknesses or non-compliance identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives.	Controls are applied but with some significant lapses
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives.	Significant breakdown in the application of controls

Control Types		
Type	**Description**	**Examples**
Preventative	Activity to control the underlying risk cause and prevent it happening in the first place	• Removal / substitution of a hazard • Employee vetting / checks • Segregation of duties / authorisation levels to reduce fraud • Restricting access to assets (physical / information) • Password protection • Policies, standards, processes for planning

Contingency (Reactive)	Corrective – limits the scope for loss, reduced undesirable outcomes Directive – direct activity to ensure a particular outcome is achieved Detective – designed to identify occasions when undesirable outcomes have been realised	• Policies, standards, processes to provide direction as to steps required in a certain situation • Budget review / reconciliation process • Performance review – budget-to-actual comparison to identify variance, Key Risk Indicators • Reporting • Inventories • Business Continuity / Disaster Recovery Plans • Whistleblowing / Fraud Detection



Risk Control Effectiveness Assessment

Effectiveness Score	Description
Fully effective: 100% Review and monitor existing controls	Nothing more to be done except review and monitor the existing control. Control is well designed for the risk, and addresses root causes. Management believes it is effective and reliable at all times. Full compliance with statutory requirements, comprehensive procedures in place, no other controls necessary, ongoing monitoring only Control is likely to be of a preventative nature (for example, prevents the risk from occurring) and be systematic or automatic (for example, electronic banking authorisation process)
Mostly Effective: 80-99% Most controls are designed correctly and are in place and effective.	Control is designed correctly and largely in place, effective and regularly reviewed. Some more work to be done to improve operating effectiveness or management has doubts about operational effectiveness and reliability.
	Control is likely to be of a preventative nature (for example, prevents the risk from occurring) but may not be automated and require manual intervention / review

Partially effective: 50-79% Some controls poorly designed or not effective	While the design of control may be largely correct in that it treats the root of the risk, it is not currently very effective. **or** While it operates effectively, the control does not seem correctly designed in that it does not treat root causes. Reasonable compliance with statutory requirements established, some preventative measures in place, controls can be improved Control is likely to be either reactive (for example, business continuity plan) or of a deterrent nature (for example corporate policy, training) and as such would not be considered as effective as a purely preventative control
Not effective: <50% Significant control gaps due to poor control design or very limited operational effectiveness	Significant control gaps. Either control does not treat root causes or does not operate at all effectively. Virtually no credible control. Management has no confidence that any degree of control is being achieved due to poor control design or very limited operational effectiveness Insufficient control, weak procedures, limited attempt made to implement preventative measures Control is either not in place or not working as intended

Effectiveness of Controls – Questions to Ask:

- Do the controls in place already work – have they prevented the risk materialising or mitigated its effects?

- Are there any gaps in controls?
- Is further information required about the cause and impact of the risk in order to design and implement appropriate controls?
- If several controls are required for mitigation, how are they prioritised?
- Are there any dependencies or critical points of failure in implementing the controls?
- Will planned controls be sufficient to bring the risk to target score?

Risk Control Criticality Assessment	
Control Rating	**Description**
Low Importance	The control is of negligible importance in effectively mitigating the risk. Failure of the control will not result in an increase in the likelihood or impact of the risk.
Moderately Important	The control is of moderate importance in effectively mitigating the risk. Failure of the control will result in an increase in the likelihood or impact of the risk, but the risk score will remain within appetite.
Important	The control is important in effectively mitigating the risk. Failure of the control will result in an increase in the likelihood and impact of the risk beyond risk appetite, but within tolerance. Additional controls will be required to mitigate the risk if this control cannot be executed.
Very Important	The control is very important in effectively mitigating the risk. Failure of the control will result in an increase in the likelihood and impact of the risk beyond risk appetite and tolerance. Significant additional controls will be required to mitigate the risk if this control cannot be executed.
Absolutely Critical	The risk control is an essential component of the mitigation plan for the risk. If the control is not in place and working effectively the risk cannot be successfully mitigated to within risk appetite or tolerance.

1st Line of Defence: The function that owns and manages the risk

Under the first line of assurance, operational management has ownership, responsibility and accountability for directly assessing, controlling and mitigating risks.

2nd Line of Defence: Functions that oversee or specialise in risk management, compliance and governance

The second line of assurance consists of activities covered by several components of internal governance (compliance, risk management, quality, IT and other control departments). This line of defence monitors and facilitates the implementation of effective risk management practices by operational management and assists risk owner in reporting adequate risk related information up and down the organisation.

3rd Line of Defence: Functions that provide independent assurance – e.g. Internal and External Audit

Internal audit forms the organisation's third line of assurance. An independent internal audit function will, through a risk based approach to its work, provide assurance to the organisation's board of directors and senior management. This assurance will cover how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence. It encompasses all elements of an institution's risk management framework (from risk identification, risk assessment and response, to communication of risk related information) and all categories of organisational objectives: strategic, ethical, operational, reporting and compliance.

Examples of Assurance Activity

- Training
- Policies and Procedures
- Communication, Consultation and Information
- Executive Management / Assurance Committee Oversight
- Management Review and Reporting (1st Line of Defence)
- Independent Review (2nd Line of Defence) – e.g. internal compliance functions such as Finance, Legal, Risk Management, Procurement, Information Governance, Infection Control, Emergency Planning / Resilience etc etc
- Internal and External Audit (3rd Line of Defence)

APPENDIX D: RISK APPETITE AND TOLERANCE LEVELS

Impact Category	Appetite	Tolerance
Health and Safety	**Averse**	**No Tolerance**
Service/Business Interruption	**Averse**	**Cautious**
Workforce	**Averse**	**Cautious**
Patient Harm	**Cautious**	**No Tolerance**
Patient Experience	**Cautious**	**Moderate**
Financial	**Cautious**	**Moderate**
Adverse Publicity / Reputation (Public Confidence)	**Cautious**	**Moderate**
Inspection / Audit	**Cautious**	**Moderate**
Health Inequalities	**Cautious**	**Moderate**
Transformation/Innovation	**Moderate**	**Open**
Environmental Sustainability and Climate Change	**Moderate**	**Open**

APPENDIX E: RISK APPETITE STATEMENTS

Impact Category	Appetite Level/Statement	Tolerance Statement
Patient Harm	Cautious: NHS Forth Valley exists to deliver safe, effective, person-centred care to its population. We recognise that to meet patient care objectives where the benefit exceeds the risk, there are occasions where we must operate with a **CAUTIOUS APPETITE** for risks which could result in patient harm.	There is no tolerance for this type of risk.
Patient Experience	Cautious: NHS Forth Valley has a sustained focus on improving care and experience of patients, families, and carers. We have a **CAUTIOUS APPETITE** for risk, reflecting our desire for positive patient experience and quality clinical outcomes, but recognising that it is not possible to avoid all risk and uncertainty in this area, particularly in the current operating environment.	Moderate: We are prepared to operate in the **MODERATE TOLERANCE** range for Patient Experience for a defined period, to ensure that essential health and social care needs are quickly and effectively met, and while mitigation plans are being actively developed.

Transformation/Innovation	Moderate: NHS Forth Valley has a **MODERATE appetite** for innovation, accepting that a greater degree of risk is required to maximise innovation and opportunities to improve patient experiences and outcomes, transform services and ensure value for money.	Open: We will operate with an **OPEN TOLERANCE for innovation** to allow the scoping of innovation projects to provide the detail of the case for change. This would be for a defined period while all potential delivery options are considered. Once in the initiation and planning stage for the innovation project to be implemented, the appropriate appetite level would be reconsidered in line with organisational process for initiating a new project.
Health and Safety	Averse: Any injury, illness or loss of life as a result of NHS FV failing to comply with Health and Safety obligations would be unacceptable. Therefore, there is an **AVERSE APPETITE** for risks that may compromise the Health and Safety of patients, staff, visitors and public and others accessing NHS FV services/venues.	There is no tolerance for this type of risk, but we recognise that on some occasions we will have to accept risks that have been reduced as low as reasonably practicable, and these are likely to fall into the cautious range.

Service/Business Interruption	Averse: NHS Forth Valley has an **AVERSE APPETITE** for risks which could result in Service/Business Interruption. Delivery of Health and Social Care is a priority, and while it may not be possible to eliminate risk, there is a focus on ensuring that essential health and social care needs are met quickly and effectively.	Cautious: We are prepared to operate in the cautious tolerance range for Service/Business Interruption for a defined period of time while mitigation plans are being actively developed.
Workforce	Averse: NHS Forth Valley is committed to recruiting and retaining a confident, flexible, trained workforce. We have an **AVERSE APPETITE** for risks to staffing, competence and wellbeing, particularly those which could result in contravention of relevant Professional Standards. It may not always be feasible to reach the desired range of outcomes, but nonetheless this is an area which we will prioritise until risks are ALARP*.	Cautious: NHS Forth Valley will operate with a **CAUTIOUS TOLERANCE,** to support staff to innovate and improve their workplace, balancing the risk against the reward to be gained from the significant staff knowledge and experience which is available. This will be for a defined period while mitigation plans are implemented. The priority will remain adherence to professional standards, and staff should continue to work within the limits of their competence, exercise “duty of candour” and raise concerns when they come across situations that put patients or public at risk.

Financial	Cautious: NHS Forth Valley's strategic aim is high quality and sustainable clinical services. We wish to achieve financial sustainability by spending well and making the most of our resources. Therefore, we have a **CAUTIOUS APPETITE** for Financial risk as budgets are constrained and unplanned / unmanaged budget variance could affect our ability to achieve statutory financial targets, potentially increases reputational risk and places pressure on divisions and departments. Well informed risks can be taken but budget variances are to be minimised and VFM is the primary concern.	Moderate: We will operate with a **MODERATE TOLERANCE** for a defined period while mitigation plans are implemented. We are prepared to accept the possibility of limited unplanned / unmanaged budget variance. VFM is the primary concern but we are willing to consider other benefits for a limited budget variance.
Inspection/Audit	Cautious: NHS Forth Valley has a **CAUTIOUS APPETITE** for risks impacting on Inspection/Audit. We are prepared to take informed risks which could result in recommendations, improvement notices or criticism, provided that the benefit outweighs the negative outcome.	Moderate: NHS Forth Valley has a **MODERATE TOLERANCE** for risks impacting on Inspection/Audit. Due to constraints in the current operating environment, we are prepared to take informed risks, for a defined period, which could result in recommendations, improvement notices or criticism, even where the benefits/negative impacts are balanced.

Public Confidence	Cautious: NHS Forth Valley has a **CAUTIOUS APPETITE** for risks impacting on public confidence which flow from informed decision-making, in order that achievement of strategic objectives is not hindered.	Moderate: We are prepared to operate within a **MODERATE TOLERANCE** range for Public Confidence for a defined period of time while mitigation plans are being actively developed.
Health Inequalities	Cautious: NHS Forth Valley has a **CAUTIOUS APPETITE** as there is a need to take a degree of balanced risk to achieve potential rewards from undertaking costeffective prevention activities and addressing health inequalities. We are focused on reducing healthcare generated inequalities.	Moderate: Recognising that tackling health inequalities requires integrated working across the whole health and care system, NHS Forth Valley has a **MODERATE TOLERANCE** to allow partners to actively collaborate to develop mitigation plans.
Environmental Sustainability and Climate Change	Moderate: NHS Forth Valley has a **MODERATE APPETITE** for risks impacting on Environmental Sustainability and Climate Change, being mindful of our commitment to reaching net zero, and of the negative impact on the health of our population.	Open: It would not be appropriate to have an open appetite due to the effect of climate change on the long-term health of the population we serve. However, we will operate in the **OPEN TOLERANCE** range while we actively seek mitigations which provide value and sustainability.

NHS Forth Valley

Forth Valley NHS Board

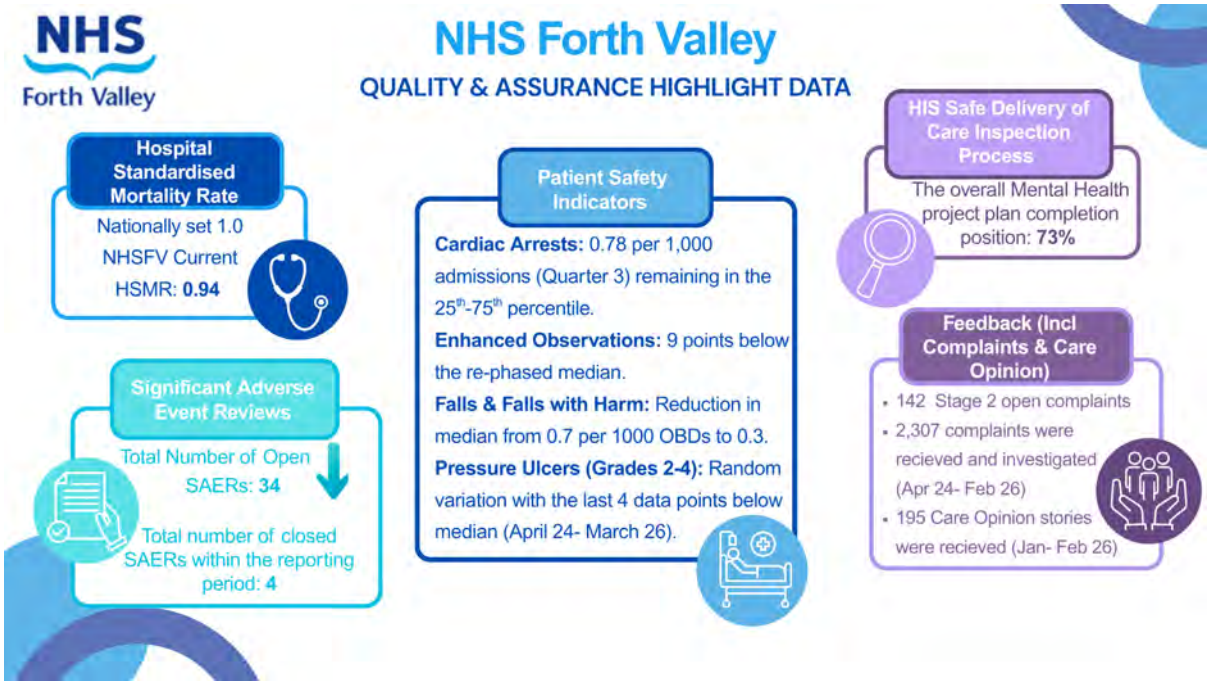
12(a) Quality Assurance and Improvement Report
Purpose: This report is for Assurance

Executive Sponsor: Andrew Murray, Medical Director & Karen Goudie, Executive Nurse Director

Authors: Wendy Nimmo, Interim Head of Efficiency, Improvement and Innovation, Ashley Calvert, Head of Clinical Governance, Scott Burton & June McGill, Quality Improvement Advisors, David Watson, Lynsey Sutherland & Mairi McDermid, Directors of Nursing and Midwifery, Pauline Donnelly, Person Centred Manager.

Executive Summary

This Quality and Assurance Report provides an overview of NHS Forth Valley's current position in relation to key areas of Quality and Safety performance.


NHS Forth Valley
NHS Forth Valley
QUALITY & ASSURANCE HIGHLIGHT DATA
Hospital Standardised Mortality Rate
Nationally set 1.0
NHSFV Current HSMR: 0.94
Significant Adverse Event Reviews
Total Number of Open SAERs: 34
Total number of closed SAERs within the reporting period: 4
Patient Safety Indicators
Cardiac Arrests: 0.78 per 1,000 admissions (Quarter 3) remaining in the 25th-75th percentile.
Enhanced Observations: 9 points below the re-phased median.
Falls & Falls with Harm: Reduction in median from 0.7 per 1000 OBDs to 0.3.
Pressure Ulcers (Grades 2-4): Random variation with the last 4 data points below median (April 24- March 26).
HIS Safe Delivery of Care Inspection Process
The overall Mental Health project plan completion position: 73%
Feedback (Incl Complaints & Care Opinion)
142 Stage 2 open complaints
2,307 complaints were recieved and investigated (Apr 24- Feb 26)
195 Care Opinion stories were recieved (Jan- Feb 26)

The appendices provide further detail on the following key areas:

- Healthcare Improvement Scotland - Safe Delivery of Care Inspection Process
- Feedback including complaints and Care Opinion
- Safety Steering Group
- Hospital Standardised Mortality Rate
- Significant Adverse Event Reviews
- Patient Safety Indicators

Action Required

The Forth Valley NHS Board is asked to:

(1) review the key areas of Quality and Safety contained within the report, noting the areas of progress and risk.

(2) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration
This matter has previously been considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Discussions undertaken on detail within paper at Clinical Governance Committee, Clinical Governance Working Group and Quality Board Seminar
- Extraordinary meeting with Chair of CGC, Medical Director, Nurse Director, Interim Head of Quality and Head of Clinical Governance to further refine

Agreement that moving forward oversight of the paper with confirmation of content will be agreed at Clinical Governance Committee prior to submission to Board.

Risk Assessment and Mitigation
There is one current operational risk relating to Significant Adverse Event Reviews (SAER) – CLINGOV 02 SAER Framework. This risk is currently being considered for escalation from operational to organisational level with a completion date of June 2026 for this work. This risk is presently assessed as high (score 15), with a target risk assessment of medium (score 10). A comprehensive programme of work is now progressing, with initial adverse event reporting and management improvements actioned. Further development in relation to adverse event escalation and commissioning will be implemented within Safeguard by the end of April 2026, with an accompanying training programme to facilitate. Additional resource for the Corporate Clinical Governance team is being progressed through recruitment processes, with expectation of posts filled in the next month.

These actions demonstrate that robust plans are in place and work is ongoing to reduce the risk to an acceptable level, providing assurance to the Board that appropriate controls and oversight are being maintained throughout the mitigation period.

NHS Forth Valley currently has open, 6 stage 1 complaints and 140 Stage 2 complaints, with the number of complaints exceeding the 20-working day response target significantly reducing over time. February performance is noted as 79.1% responded to within 20 working days demonstrating month on month improvement.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty
Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial, Digital and Infrastructure Implications
There are potential financial implications arising from this report in relation to the resources required to sustain and improve the SAER facilitation process. Infrastructure implications may arise from the adverse event reporting system used by NHS Forth Valley and the planned replacement to Healthcare Guardian (Inphase) as the organisation realigns to a new critical system.

Work continues to explore the opportunity to stabilise the workforce within the patient relations team, recognising that several posts are currently on a temporary basis.

Workforce Implications
The escalation of adverse events and the ongoing SAER process have notable workforce implications. There are current pressures on capacity and resources within both Corporate Clinical Governance and Health & Safety departments, given the demands of the existing work plan commitments. The mitigation programme requires sustained engagement from these teams to ensure effective management and oversight of significant adverse events. In addition, the recent business case for extra resource within Corporate Clinical Governance will support the timeously review of SAERs aligned to the HIS National Framework.

Quality / Patient Care Implications
NHS Forth Valley participates in the recently launched Scottish Patient Safety Programmes (SPSP) for Mental Health, Adults in Hospital and Medicines Management and these programmes align with national safety priorities and reinforce the Board's commitment to continuous improvement in patient care. Implementation will require sustained workforce engagement, potential resource investment, and integration into existing governance structures through the Quality and Safety Steering Groups.

The programmes also support risk mitigation efforts and enhance assurance mechanisms, while contributing positively to NHS Forth Valley's compliance with national standards.

The newly established Safety Steering group aligned to the refreshed Patient Safety Indicator Subgroups E.g. Deteriorating Patients will provide a reporting and assurance mechanism to the Quality Programme Board and the Clinical Governance Working Group, confirming progress against agreed national and local safety and quality measures. It will monitor implementation of safe care initiatives, improvement projects, and innovation within its remit, ensuring compliance with local and national standards.

NHS Forth Valley's approach to Excellence in Care is embedded within a mature, multi-layered quality management system across NMAHP services. The Excellence in Care (EiC) Care Assurance Visit and Quality of Care Model is utilised as one element of a broader suite of assurance mechanisms, providing structured, in depth insight into lived experience, care delivery and professional practice. This is complemented by a range of additional intelligence sources across the system to ensure triangulated, proportionate assurance. Measurement and oversight are informed by nationally agreed Excellence in Care measurement plans, ensuring that indicators used are evidence based, meaningful and focussed on value adding assurance. This approach enables NHS Forth Valley to maintain a clear line of sight from practice level quality and safety through to Board level assurance, supporting continuous improvement and compliance with national quality and staffing expectations. See below for examples.

Measure Name	Jan-Mar 2025	Apr-Jun 2025	Jul-Sep 2025	Oct-Dec 2025
Accurate Early Warning Score	80%	84%	78%	89%
Completion of Initial GIRFEC Assessment	N/A	0%	52%	79%
Correct Frequency of Early Warning Scores	83%	84%	78%	89%
Establishment Variance	53%	93%	93%	93%
FFN Care Plan	69%	81%	90%	93%
FFN MUST Score	69%	81%	90%	93%
FFN Nutritional Assessment	69%	81%	90%	93%
Inpatient Falls Rate	94%	93%	92%	92%
MEWS Compliance	33%	89%	100%	100%
MEWS Escalation	33%	0%	0%	0%
Mental Health Person-Centred Care Planning	40%	47%	52%	52%
Multi-Drug Resistant Organism (MDRO) Admission Screening	0%	0%	0%	0%
Neonatal Temperature Measurement	100%	100%	100%	100%
PEWS Compliance	100%	100%	100%	100%
PEWS Escalation	100%	100%	100%	100%
Predictable Absence Allowance	53%	95%	99%	100%
Preferred Place of Death Achieved	80%	90%	100%	97%
Preferred Place of Death Documented	80%	90%	100%	97%
Pressure Ulcer Rates	92%	92%	92%	92%
QMPLE Score	30%	48%	44%	43%
QMPLE Student Feedback	51%	56%	53%	51%
School Nursing Referral Assessment	N/A	0%	67%	100%
Stress and Distress	83%	100%	83%	100%
Supplementary Staffing Use - Bank and Agency	86%	93%	94%	93%
Supplementary Staffing Use - Overtime and Excess	53%	93%	93%	93%

Table 1, Quarterly submission rates (%) by measure in NHS Forth Valley

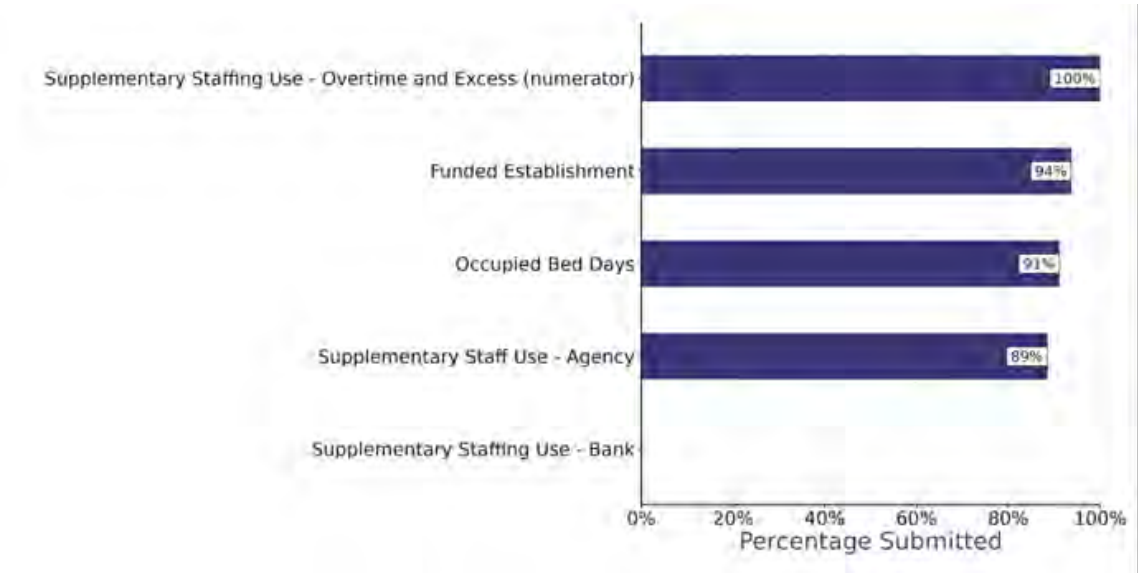


Figure 1: Submission rates (%) by partial measure in the latest month (February 2026) in NHS Forth Valley

Following the Quality Board Seminar in March 2026, it was agreed that Forth Valley will continue to improve our organisational Quality Management System (QMS). Benchmarking and building on the already established Nursing, Midwifery & Allied Health Professionals (NMAHP) QMS as the enabling approach for delivery of an Organisational Safety Plan, following completion of Forth Valley's current Quality Strategy. The QMS will provide the structured governance, standardised ways of working and assurance required to support the implementation of the Population Health Strategy and Quality, Safety and Experience ambitions.

Population Health & Care Strategy
The content of this report is intrinsically linked to NHS Forth Valley's Population Health & Care Strategy through its commitment to continuous improvement in patient safety, organisational learning, and the delivery of high-quality care.

Climate Change / Sustainability Implications
No immediate implications.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

Appendices
Appendix 1 - (Quality Assurance) Healthcare Improvement Scotland - Safe Delivery of Care Inspection Process
Appendix 2 - (Patient Experience) Feedback including complaints and Care Opinion
Appendix 3 - Safety Steering Group
Appendix 4 - Hospital Standardised Mortality Rate
Appendix 5- Significant Adverse Event Reviews
Appendix 6 - (Improving Quality) Patient Safety Indicator

Appendix1- (Quality Assurance) Healthcare Improvement Scotland Unannounced Inspection Process

Acute Services

Healthcare Improvement Scotland (HIS) undertook an unannounced Safe Delivery of Care follow up inspection on 16 March 2026 from the 2024 SDC inspection requirements. Subsequently an unannounced follow-up visit was undertaken again on 7 April 2026. Following the follow-up visit Operational and Senior Oversight Groups have been established to govern the delivery of the action plan. Additional evidence is due to be submitted by Friday 10 April.

Visit on 16 March 2026
Verbal Feedback
Request for Evidence
HIS & Board Evidence Discussions
Draft Report from HIS
Factual Accuracy Response by NHS FV
Final Report from HIS
18-week Action Plan Submission & Oversight Set Up
HIS Publication of 18-week Action Plan
Assurance & Improvement Oversight

Figure 1, Acute Services HIS Inspection Pathway Position

Maternity Services

Following the unannounced HIS maternity inspection and the final report issued on 27 November 2025, NHS Forth Valley has made clear and demonstratable progress across the recommendations and requirements relating to Women & Children's services. NHS Forth Valley have now submitted our 18-week Action Plan, and overall NHS Forth Valley can provide assurance that meaningful progress has been achieved, with the majority actions embedded and showing a sustained improvement. The strengthened governance structures now in place provide a robust framework to maintain oversight, ensure continued compliance, and support ongoing improvement across the Women & Children's services. The action plan is being monitored by the Clinical Governance Committee.

Visit on 27 November 2025
Verbal Feedback
Request for Evidence
HIS & Board Evidence Discussions
Draft Report from HIS
Factual Accuracy Response by NHS FV
Final Report from HIS
18-week Action Plan Submission & Oversight Set Up
HIS Publication of 18-week Action Plan
Assurance & Improvement Oversight

Figure 2, Maternity Services HIS Inspection Pathway Position

Mental Health Services

Oversight and Operational Groups have been established to lead and monitor the delivery of the action plan in response to the recommendations and requirements from the report. This co-ordinated approach provides the necessary leadership oversight, vigilance and traction on requirements. The 18-week Action Plan update will be requested by Healthcare Improvement Scotland 18 weeks post publication date which would be expected in May. Work is progressing to ensure readiness of evidence to update for the publication of our progress via the 18-week Action plan.

Visit on 27 November 2025
Verbal Feedback
Request for Evidence
HIS & Board Evidence Discussions
Draft Report from HIS
Factual Accuracy Response by NHS FV
Final Report from HIS
18-week Action Plan Submission & Oversight Set Up
HIS Publication of 18-week Action Plan
Assurance & Improvement Oversight

Figure 3, Mental Health Services HIS Inspection Pathway Position

Appendix 2- Patient Experience (Including Complaints and Care Opinion) Complaints Update

NHS Forth Valley had a significant backlog of complaints where people have waited more than the national standard of 20 working days. Total number of open Stage 2 complaints across all operational units totalled 526 at the initiation of the improvement plan.

Stage 2 Current Position 137 open complaints.

A wider improvement plan has been developed to support improved performance regarding our statutory responsibility to respond to people and their families on time. This includes General Data Protection Regulation aspects including a review of Complaints Handling Procedure, developing a standard operating procedure, revised proforma to support responding to complaints, undertaking an audit of SPSO cases, performance measures, developing a dashboard and training for team members.

Improvement aims have been developed to improve our position across national complaints performance indicators.

The run chart below demonstrates the statistical improvement over time in open stage two complaints and provides assurance that the processes in place are effective:

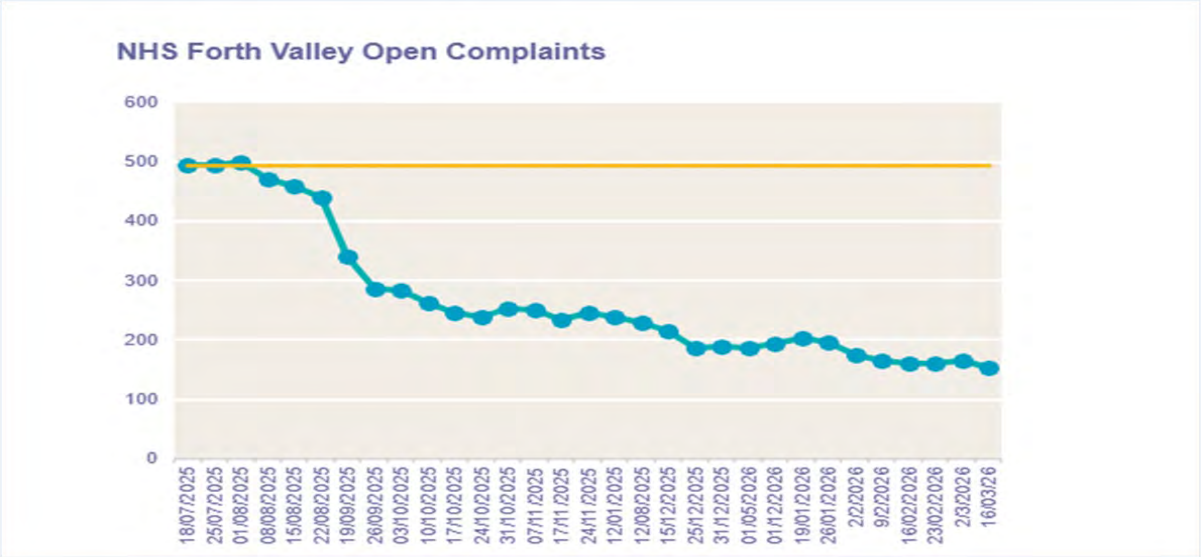


Chart 1: NHSFV Number of Open Stage 2 Complaints

Care Opinion
During the months of January and February 2026 we have received 195 Care Opinion stories, to date the stories have been read 15,531 times. For the month of January 2026, we received 94 stories and for February 2026, of that 86% of stories posted were rated as non-critical/ minimally critical.

What was good?
- Patients fed back that staff were professional and friendly.
- Patients were grateful for the level of care they were provided with.

What could be improved?
- Communication
- Lack of Support
- Staff Attitude

The improvements from these complaint themes form the basis of both specific feedback to teams for action, and learning that is brought into clinical governance discussions.

NHS Forth Valley is currently in discussions with Healthcare Improvement Scotland and Scottish Government to consider the activation of the Care Opinion Dashboard which was previously tested across NHS Scotland. This will provide the Board with thematic analysis of Care Opinion Feedback across Forth Valley. Through the Excellence in Care PREM work we intend to work in partnership to develop data intelligence as a test of change to inform national planning and learning. We have approached our Stirling University partners to consider participating in the evaluation.

Appendix 3 - Safety Steering Group

The Safety Steering Group is now operational, with agreed governance structures, emerging standardised reporting, and a clear focus on organisational safety oversight. The Group is progressing from establishment and design into routine assurance and escalation, with appropriate reporting to Clinical Governance Working Group, and on to the Clinical Governance Committee, and Quality Programme Board.

The ToR and governance structure were actively refined through iterative discussion between senior leaders and the Quality Team, ensuring the remit was appropriately broad and not limited to individual programmes or datasets.

The operational units will commence reporting on safety action plans and measurement frameworks, ensuring alignment with both NHS Forth Valley strategic priorities and national improvement programmes.

Appendix 4 – Hospital Standardised Mortality Rate (HSMR)

Why is it important?

It is a key and overarching indicator of the quality and safety of our care in the acute hospital. The Scottish HSMR is 1.00. If an HSMR value for a hospital is less than 1.00, this means the number of deaths within 30 days of admission for this hospital is fewer than predicted. If an HSMR value for a hospital is greater than one, this means the number of deaths within 30 days for this hospital is more than predicted. If the number of deaths is more than predicted this does not necessarily mean that these were avoidable deaths (i.e. that they should not have happened), or that they were unexpected, or were attributable to failings in the quality of care.

How are we doing?

In NHS Forth Valley the value of HSMR has remained below 1.0 since the previous report, with the latest report identifying rate of 0.94. NHS Forth Valley is within control limits on the national funnel chart below.

Hospital Standardised Mortality Ratio
Publication Date: 10th February 2025

Latest Hospital Standardised Mortality Ratio

Please note that as of August 2019, HSMR is presented using a 12 month reporting period when making comparisons against the national average. This will be advanced by three months with each quarterly update.

Crude mortality values presented here are reflective of the latest 12 month HSMR reporting period. For crude mortality trends by individual quarter please refer to **Crude Trends (Overall)**.

Health Board of Treatment: NHS Forth Valley

Period: October 2024 to September 2025

Location	Observed Deaths	Predicted Deaths	Patients	Crude Rate (%)	HSMR	Comparison to Scotland on the Funnel Plot
Scotland	**26,006**	**26,006**	**663,760**	**3.9%**	**1.00**	**n/a**
NHS Forth Valley	1,353	1,433	34,783	3.9%	0.94	n/a
Forth Valley Royal Hospital	1,352	1,429	33,572	4.0%	0.95	●

Figure 4: ISD Scotland, Hospital Standardised Mortality Ratio

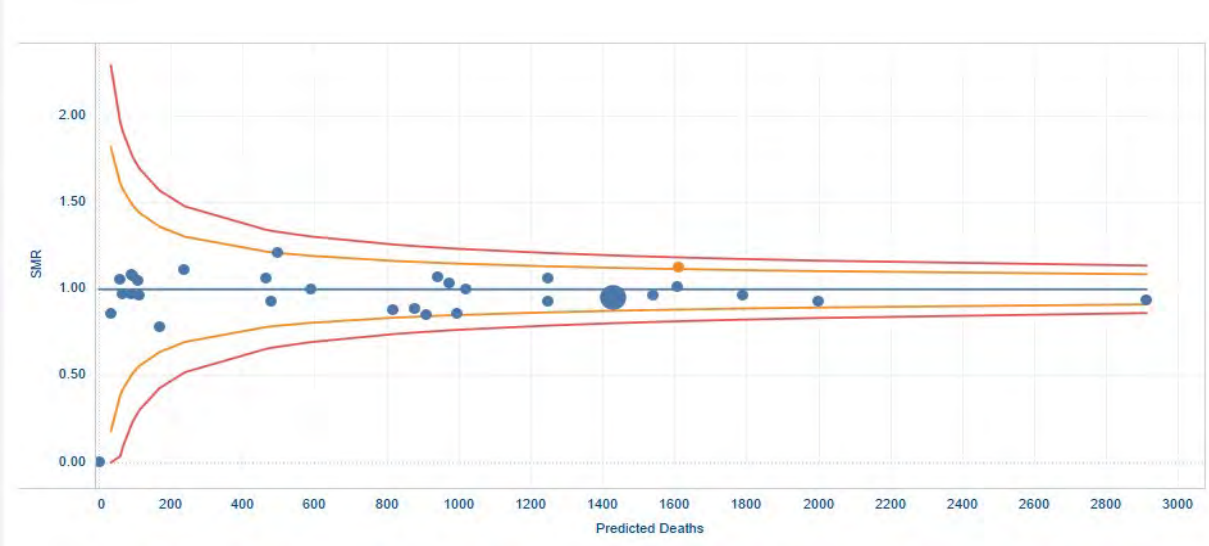


Chart 2: ISD Scotland, NHSFV funnel plot position HSMR

Appendix 5 – Significant Adverse Event Reviews

Healthcare Improvement Scotland (HIS) issued a revised framework in February 2025 to standardise the management of significant adverse events and is now undertaking an evaluation and workshop programme with all NHS Scotland Boards to support collaborative improvement of the SAER process.

This report provides NHS Forth Valley Board with an update on significant adverse events (SAEs), including the current position and progress of significant adverse event reviews (SAERs) within NHS Forth Valley.

The Board currently has 34 open SAERs; 9 of which are at draft report stage.

Temporary resource has been approved for the Corporate Clinical Governance Department to support completion of the backlog of historic SAERs, with the intention that this is completed by the end of 2026 and to ensure capacity to commence newly commissioned SAE reviews in 2026 in as real-time a way as possible. The barriers to achieving these ambitious timelines are: recruitment delay, need for training and clinical time to support the processes, all of which are being mitigated by expediting the recruitment, minimising the training and using experienced staff, and allowing clinical staff to substitute SAER involvement for clinical work.

The Board has identified quality improvement, and assurance aims (short-term aims and longer-term stretch aims) to measure progress in adverse event management, escalation and the SAER process.

The overarching aim by December 2027 is to improve the timeliness, quality and governance of adverse event (AE) reviews, ensuring appropriate escalation and completion within expected timeframes, in line with the HIS framework, with an aim of 95% of all SAER meeting the 140 working day completion timeframe.

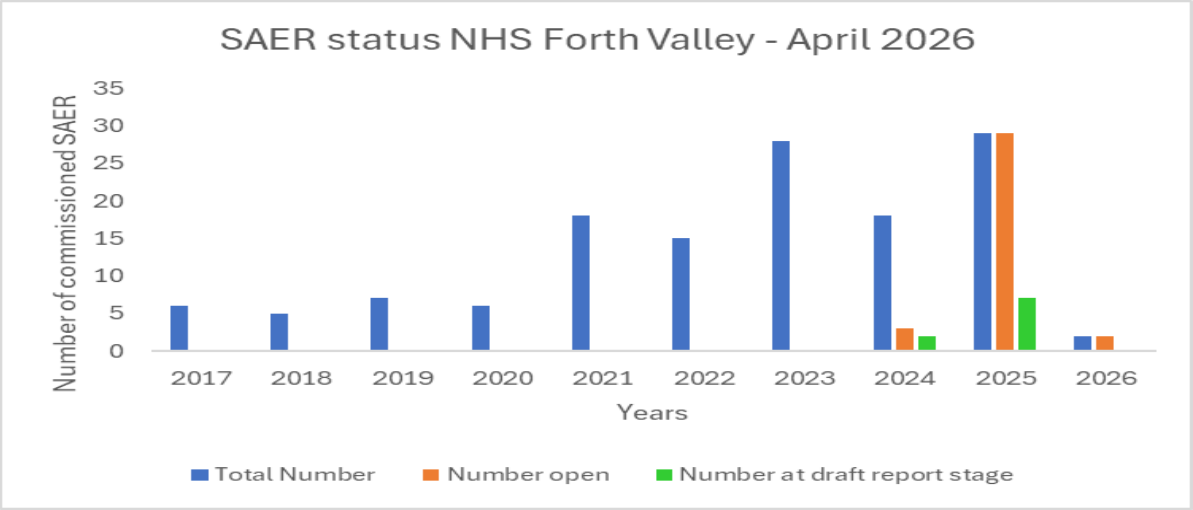


Chart 3: Status of SAERs in NHSFV

Appendix 6- (Improving Quality) Patient Safety Indicators

Deteriorating Patients - Cardiac arrest

Aim: We are currently reviewing our aim to ensure alignment with the SPSP Acute Adult updated change package which is currently under review and due to be published in Summer 2026.

Outcome: SPSP Data (Chart 4) from October 2025 to January 2026, indicates early signs of improvement with 5 points below the current median with a rate of 1.65 in February 2026. This is largely attributed to the considerable work that has been undertaken around Person–Centred decision making and treatment escalation plans.

FVRH participates in the National Cardiac Arrest Audit. In the last reporting quarter (quarter 3) the rate per 1,000 admissions was 0.78 (Chart 5) and remains in the 25th-75th percentile.

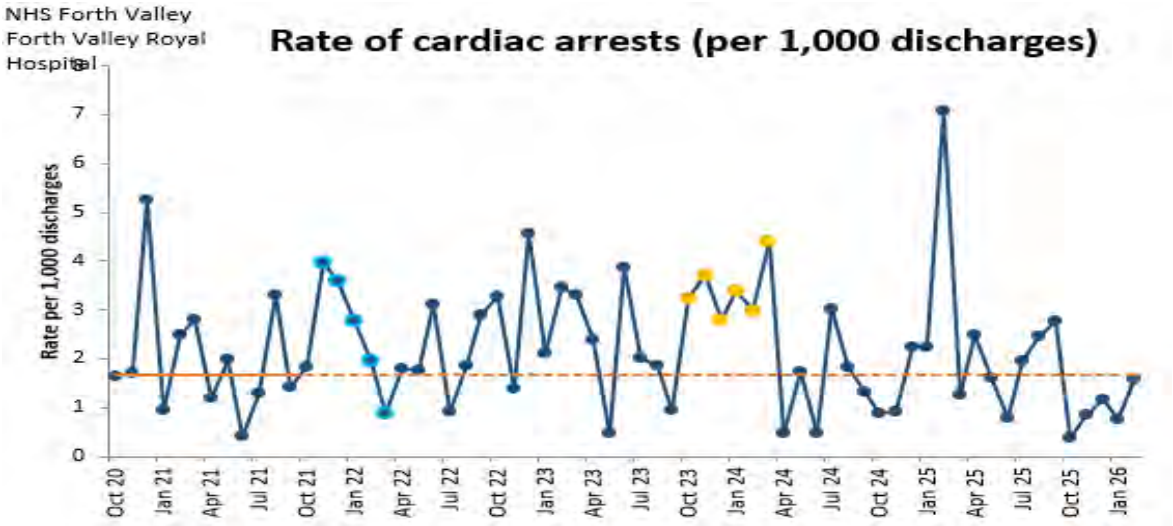


Chart 4: SPSP, Rate of Cardiac Arrests per 1,000 discharges

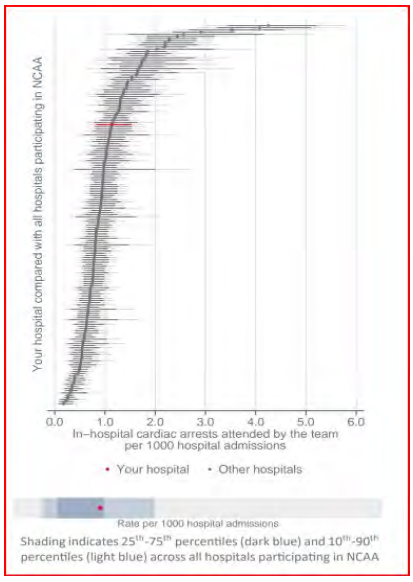

Your hospital compared with all hospitals participating in NCAA
0.0
1.0
2.0
3.0
4.0
5.0
6.0
In–hospital cardiac arrests attended by the team per 1000 hospital admissions
Your hospital
Other hospitals
Rate per 1000 hospital admissions
Shading indicates 25th-75th percentiles (dark blue) and 10th-90th percentiles (light blue) across all hospitals participating in NCAA

Chart 5: NCCA December 2025, In-hospital Cardiac Arrests attended per 1,000 hospital admissions (NHSFV compared to all hospitals participating in NCCA)

Next Steps: Reestablishment of the Deteriorating Patient Workstream reporting into the Safety Steering Group. Review and update our local change package and driver diagram aligned to SPSP programme.

Enhanced Observations
Outcome: The data (chart 6) below continues to demonstrate sustained improvement with 9 data points below re-phased median.

Next steps:
The subsequent actions for this project involve maintaining assurance oversight and ongoing monitoring, which currently remain under Quality Control. These processes will be managed by the Workforce Governance group, as well as locally through patient safety and safe staffing huddles. The methodology is being implemented within the acute mental health unit to enhance understanding of continuous observations.

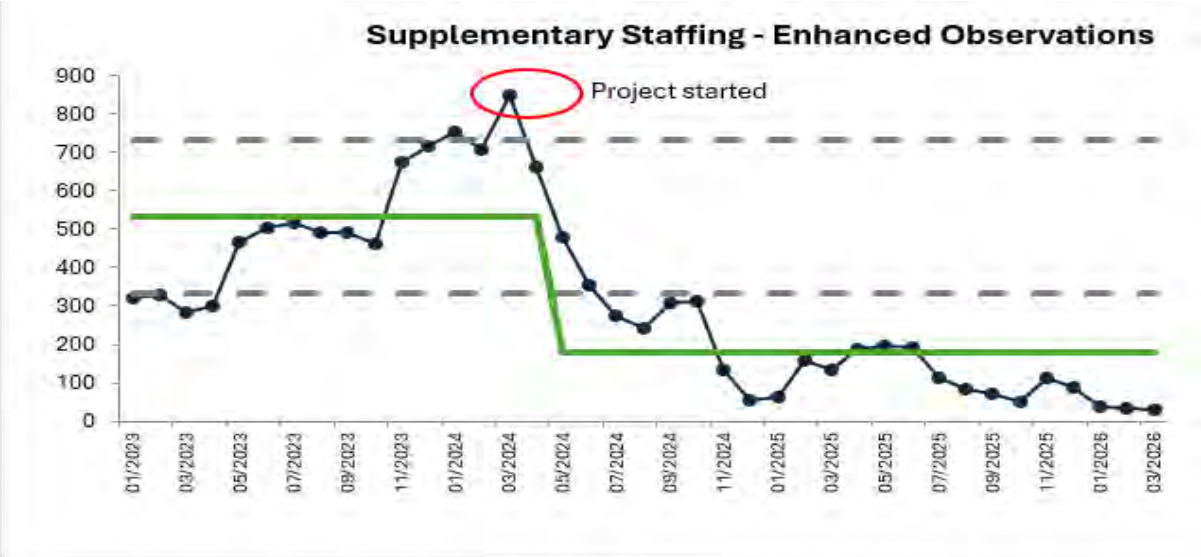


Chart 6: Enhanced Observation data (January 2023 – March 2026)

Safer Mobility – Falls & Falls with Harm
Aim: The new SPSP has a draft aim of reducing falls with harm by 10% with discussions ongoing for an updated change package.

Outcome: The median for falls with harm has reduced from 0.7 per 1000 OBD (October 2020 – September 2024) to 0.3 per 1000 OBD which has been sustained from October 2024 to February 2026. Current data shows random variation.

Next Steps: Falls and falls with harm will continue to be closely monitored, with improvement actions supported through the Safety Steering Group governance model. Ongoing improvement work will remain aligned to the SPSP Adults in Hospital Programme launched in November to ensure sustained progress and compliance with national standards. A review of our current system wide change package will be undertaken aligned to SPSP Programme.

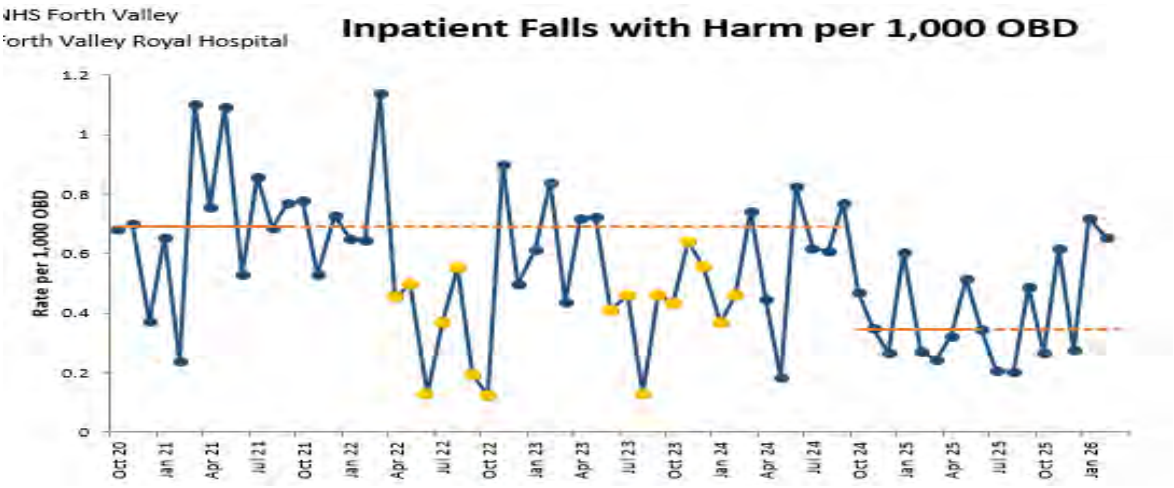


Chart 7: SPSP, Inpatient Falls with Harm per 1,000 Occupied Bed Days

Falls

Aim: Reduce Falls by 10% with discussions ongoing for an updated change package from SPSP and a local package awaiting to be developed.

Outcome: Chart 8 demonstrates there was an improvement with a reduced trend in falls from June 2025 – October 2025 with a slight increase in November 2025 however since December 2025 there are signs of improvements to March 2026. Anecdotal evidence suggests this might be due to increased mobilisation of patients across all ward settings. The Improvement survey on IR1s will help determine casual effects.

Next Steps: Reestablishment of the Safer Mobility Workstream reporting into the Safety Steering Group. Create a local change package and driver diagram aligned to SPSP programme.

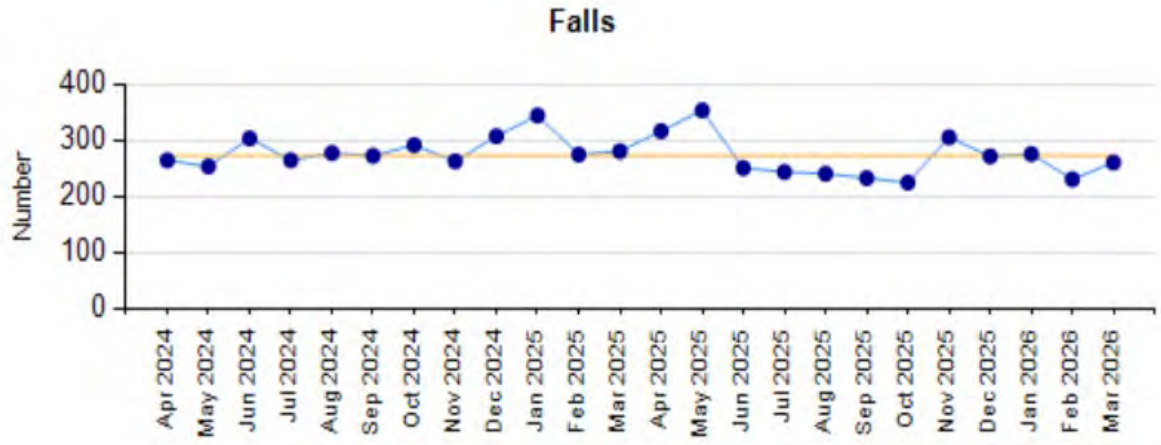


Chart 8: SSRS, Whole System Falls (January 2024 – February 2026)

Pressure Ulcers

Aim: We are currently reviewing our aim to ensure alignment with the SPSP Acute Adult updated change package which is currently under review and due to be published in Summer 2026.

Outcome: Whole system pressure ulcer data grades 2-4 shows random variation with the last 4 data points below the current median.

Next steps: Continued education and system-wide verification efforts are being maintained to ensure robust and reliable reporting. Monitoring will continue through the Safety Steering Group governance model. Ongoing improvement work will align to the SPSP Adults in Hospital Programme for continual improvement efforts.

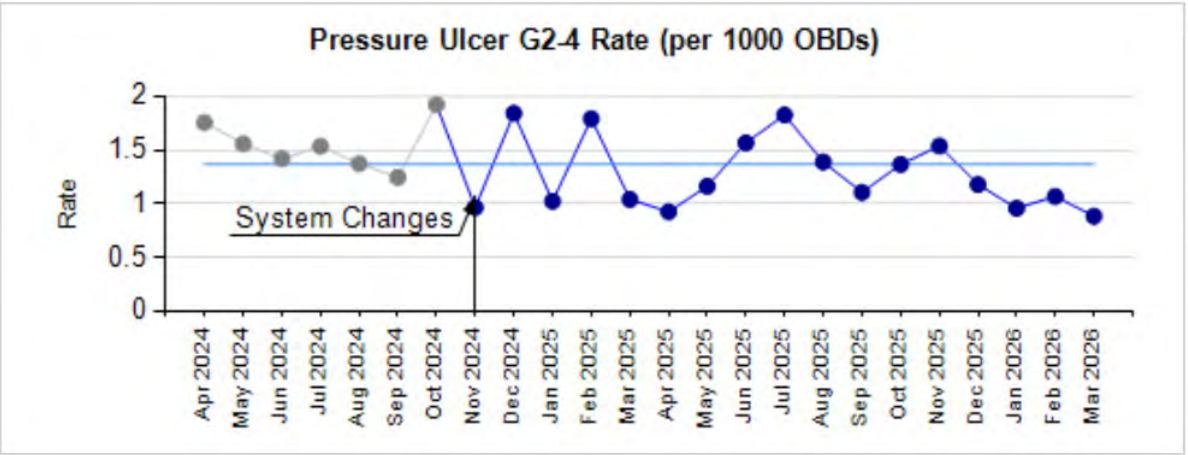


Chart 9: SSRS, Whole System Pressure ulcers, Grades 2-4 (April 2024 – March 2026)

Summary

In summary, the Quality and Assurance Report provides a level of assurance of NHS Forth Valley's current position across the key areas of quality and safety. However, there is a recognition that there is work required to strengthen the Board's position by developing an Organisational Safety Plan which will include clear measurable aims. The Plan will be underpinned by the further development of the Quality Management System and the commencement of a Safer Together Collaborative 2.0. Key to this is data and measurement, therefore we are enhancing our understanding of accessibility and visualisation of data relevant to provide assurance of safe and effective care within Forth Valley. In the longer term, the phased implementation of the Healthcare Guardian will further support improvements in data visualisation and accessibility.

NHS Forth Valley

Forth Valley NHS Board

12(b) Healthcare Associated Infection (HAI) Report March 2026
Purpose: This report is for Assurance

Executive Sponsor: Karen Goudie, Executive Nurse Director
Author: Jonathan Horwood, Infection Control Manager & Clinical Lead

Executive Summary

The Healthcare Associated Infection Reporting Template (HAIRT) is mandatory reporting tool for the Board to have oversight of the HAI targets (Staph aureus bacteraemias (SABs), Clostridioides difficile infections (CDIs), device associated bacteraemias (DABs), incidents and outbreaks and all HAI other activities across NHS Forth Valley.

- Total SABS remain within control limits. There was one hospital acquired SAB in March.
- Total DABs remain within control limits. There was one hospital acquired DAB in March.
- Total CDIs remain within control limits. There was one hospital acquired CDI in March.
- Total ECBs remain within control limits. There were four hospital acquired ECBs in March.
- Unverified data suggests NHSFV has met the SAB,ECB and CDI LDP targets.
- There were no mandatory surgical site infection in March.
- There was one outbreak reported in March.

Action Required

The Forth Valley NHS Board is asked to:

(1) note the HAIRT report.
(2) note the performance in respect for SABs, DABs, ECBs & CDIs.
(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

This matter has not been presented to any other meeting so far.

Risk Assessment and Mitigation

Work is on trajectory to reduce all reducible SABs, DABs, ECBs and CDI infections across NHS Forth Valley to meet both national and local standards/expectations.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial and Infrastructure Implications

None.

Workforce Implications

None.

Quality / Patient Care Implications
Healthcare associated infections (HAI) can result in poor outcomes for patients in terms of morbidity and mortality, increased length of stay and necessitate additional diagnostic and therapeutic interventions.

Population Health & Care Strategy
None.

Climate Change / Sustainability Implications
None.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

- If yes, please provide details.

Infection Prevention & Control Team, Infection Control Committee and Clinical Governance Committee.

Appendices
Appendix 1 – Main Report

Healthcare Associated Infection Reporting Template (HAIRT)

March 2026

Glossary of abbreviations

Following feedback from stakeholders below is a list of abbreviations used within this report:

HAI	Healthcare Acquired Infection
SAB	*Staphylococcus aureus* Bacteraemia
DAB	Device Associated Bacteraemia
CDI	*Clostridioides* Infection
ECB	Escherichia Coli Bacteraemia
AOP	Annual Operational Plan
NES	National Education for Scotland
IPCT	Infection Prevention & Control Team
HEI	Healthcare Environment Inspectorate
SSI	Surgical Site Infection
SICPs	Standard Infection Control Precautions
PVC	Peripheral Vascular Catheter

Definitions used for *Staph aureus*, device associated and *E coli* bacteraemias

Definition of a bacteraemia

Bacteraemia is the presence of bacteria in the blood. Blood is normally a sterile environment, so the detection of bacteria in the blood (most commonly accomplished by blood cultures) is always abnormal. It is distinct from sepsis, which is the host response to the bacteria. Bacteria can enter the bloodstream as a severe complication of infection (like pneumonia, meningitis, urinary tract infections etc), during surgery, or due to invasive devices such as PVCs, Hickman lines, urinary catheters etc. Transient bacteraemias can result after dental procedures or even brushing of teeth although this poses little or no threat to the person in normal situations.

Bacteraemia can have several important health consequences. The immune response to the bacteria can cause sepsis and septic shock, which has a high mortality rate. Bacteria can also spread via the blood to other parts of the body (haematogenous spread), causing infections away from the original site of infection, such as endocarditis (infection of the heart valves) or osteomyelitis (infection of the bones). Treatment for bacteraemia is with antibiotics for many weeks in some circumstances, however cases such as *Staph aureus* bacteraemia usually 14 days of antibiotic therapy is required.

Cause definitions for *Staph aureus* and device associated bacteraemia

Hospital acquired

- Hospital acquired is defined when a positive blood culture is taken >48 hours after admission i.e. the sepsis is not associated with the cause of admission. An example would a patient with sepsis associated from an infected peripheral vascular catheter.

Healthcare acquired

- Healthcare acquired is defined when a positive blood culture is taken <48 hours after admission but has in the last three month had healthcare intervention such as previous hospital admission, attending Clinics, GP, dentist etc. Note this does not necessarily mean that the sepsis is associated with the previous healthcare intervention.

Nursing home acquired

- Nursing home acquired is defined when a positive blood is taken <48 hours after admission and when symptoms associated with sepsis developed at the nursing home.

Healthcare Associated Infection Reporting Template (HAIRT)

The HAIRT Report is the national mandatory reporting tool and is presented bi-monthly to the NHS Board. This is a requirement by the Scottish Government HAI task Force and informs NHS Forth Valley (NHSFV) of activity and performance against Healthcare Associated Infection Standards and performance measures.

This section of the report focuses on NHSFV Board wide prevention and control activity and actions.

Performance at a glance:

***Staph aureus bacteraemia* - total number this month: 3**

- There was one hospital acquired SAB this month.
- There were two healthcare acquired SABs this month.
- Total SAB case numbers remained within control limits this month.

Device associated bacteraemia – total number this month: 2

- There was one hospital acquired DAB this month.
- There was one healthcare acquired DAB this month.
- Total DAB case numbers remained within control limits this month.

***Clostridioides difficile* infection – total number this month: 4**

- There was one hospital acquired CDI this month.
- There were three healthcare acquired CDIs this month.
- Total CDI case numbers remained within control limits this month.

***E coli* bacteraemia – total number this month: 10**

- There were four hospital acquired ECBs this month.
- There were four healthcare acquired ECBs this month.
- There were two nursing home acquired ECBs this month.
- Total ECB case numbers remained within control limits this month.

Surgical site infection surveillance

- There were no mandatory reported surgical site infections this month.

Outbreaks

- There was one outbreak reported this month.

LDP interim targets for 2025-2026

The publication of **Further Update on Standards on Healthcare Associated Infections DL (2025) 05** sets out the local delivery plan standards for year 2025/2026.

The agreed standard **should be no increase in the incidence (number of cases) of *Clostridioides difficile* infection (CDI), *Escherichia coli* bacteraemia (ECB), and *Staphylococcus aureus* bacteraemia (SAB) in the period between April 2025 and March 2026, from the 2023/2024 case numbers baseline.**

In accordance with this ARHAI have provided FV with our 2023/2024 baseline number of healthcare associated CDI, ECB and SAB cases to enable local monitoring. This number reflects the number of cases that should not be exceeded in 2025/26 to meet the new standard.

Healthcare associated case numbers of CDI, ECB and SAB, NHS Forth Valley.

	2023/2024 case numbers (maximum number of cases for 2025/2026)	2025/2026 case numbers to date
CDI	40	32
ECB	142	122
SAB	57	50

Unverified data suggests NHSFV has met the targets

Ongoing work to support the targets

- Regular reporting of AOP targets on a monthly basis to Executive Team and Service Leads.
- AOP targets reported to ICC, Board and Clinical Governance Committees to ensure appropriate scrutiny and progress towards targets.
- ECBs in particular urinary catheter sepsis case numbers are anticipated to fall following assessment of urinary catheter prevalence across FV as part of the Safety Collaborative work.
- Research near completion regarding PPI and biliary sepsis. Results shared with primary care and to be shared with surgical teams.
- IR1s generated for all hospital infections (ECBs, SABs, DABs and CDIs)

HAI Surveillance

NHS FV has systems in place to monitor key targets and areas for delivery. Our surveillance and HAI systems and ways of working allow early detection and indication of areas of concern or deteriorating performance. The Infection Prevention & Control Team undertakes over 180 formal ward audits per month in addition to regular weekly ward visits by the Infection Control Nurse; infection investigation is also a significant function within the team as part of our AOP target reporting. This activity provides robust intelligence of how infection prevention is maintained across all areas in Forth Valley and is reported on a monthly basis to all appropriate stakeholders.

Staph aureus bacteraemias (SABs)

All blood cultures that grow bacteria are reported nationally and it was found that *Staph aureus* became the most common bacteria isolated from blood culture. As *Staph aureus* is an organism that is found commonly on skin it was assumed (nationally) the bacteraemias occurred via a device such as a peripheral vascular catheter (PVC) and as such a national reduction strategy was initiated and became part of the then HEAT targets in 2006. Following on from the 2019-2024 AOP targets, new targets are going to be set by the Scottish Government shortly.

Total number of SABs this month; **3** compared to **7** last month.
There was no data exceedance for SABs this month.

Total number of SABs (April 2025 – date) = **50**

- Hospital acquired = **1**
  - Unknown

  There was no data exceedance for hospital acquired SABs this month.

- Healthcare acquired = **2**
  - Respiratory tract
  - UTI

  There was no data exceedance for healthcare acquired SABs this month.

- Nursing Home acquired = **0**

Hospital SABs

- **Unknown;** following investigations no definitive source of infection was identified.

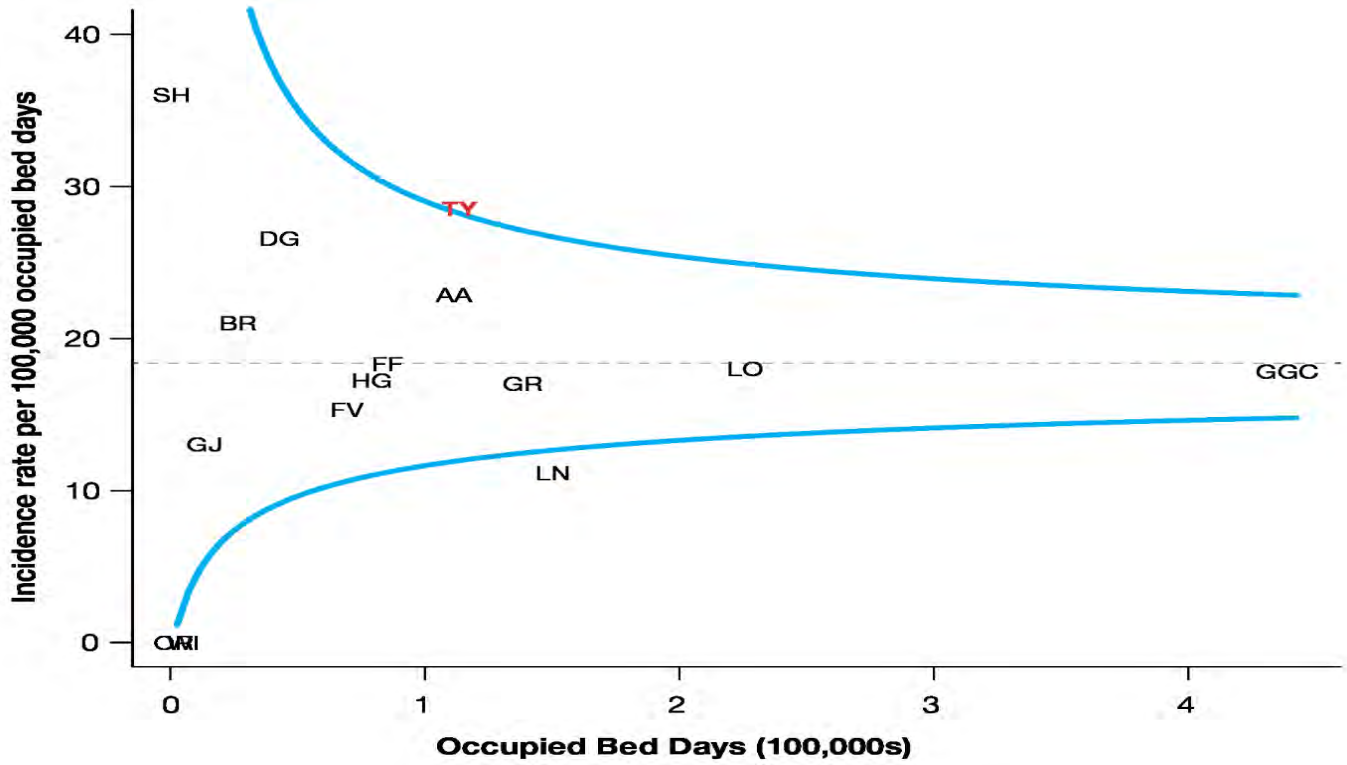
NHS Forth Valley's approach to SAB prevention and reduction

All *Staph aureus* bacteraemias are monitored and reported by the IPCT. Investigations to the cause of infection consist of examining the patients notes, microbiology, biochemistry and haematology reports to identify potential causes of the infection; from this, in most cases, a provisional cause is identified, however this is discussed further with the clinical team responsible for the management of the patient to assist further with the investigation. Any issues identified during the investigations, such as incomplete bundle completion etc is highlighted at this time and where appropriate an IR1 is reported. Once a conclusion has been agreed, the investigations are presented to the Infection Control Doctor/Microbiologist for approval. The investigation is concluded with the IPCT reporting their findings to the clinical team and management.

This data is entered into the IPCT database collated, analysed and reported on a monthly basis. The analysis of the data enables the IPCT to identify trends in particular sources of infections, such as Hickman line infections etc and identifying areas requiring further support. The data also influences the direction of the HAI annual workplan.

National Context

All SABs are reported nationally and reported on a quarterly basis. This provides our board an overview and national context of our national position compared to other boards. Due to the national reporting, unfortunately the data publish is 3 months in arrears compared to the local data presented. The funnel plot below is based on the new national AOP targets ie hospital and healthcare are represented as healthcare and provides an indication of FVs position nationally. Below is an extract from the ARHAI Quarter 4 report (October – December 2025) highlighting Forth Valley's position compared to all other boards in Scotland.



Device Associated Bacteraemias (DABs)

In addition to the nationally set targets, infections from an invasive device caused by *Staph aureus* would be investigated fully and reported, any other organism causing the same infection was not mandated to report nationally or to be investigated. As a result of this, in 2014, the IPCT started reporting all bacteraemias attributed to an invasive device regardless of the bacterium causing the infection. Due to the importance and significance of this surveillance, it is now part of our local AOP.

NHS Forth Valley's approach to DAB prevention and reduction
Continual monitoring and analysis of local surveillance data enables the IPCT and managers to identify and work towards ways to reduce infections associated with devices. All DABs are reviewed and investigated fully and highlighted to the patients' clinicians, nursing staff and management. Where appropriate an IR1 is generated to enable infections that require learning is shared and discussed at local clinical governance meetings.

In addition, on a weekly basis the IPCT assess bundle compliance of three invasive devices (PVCs, urinary catheters, CVCs etc) as part of their ward visit programme and this is reported in the monthly Directorate Reports.

Total number of DABs this month; **2** compared to **5** last month.
There was no data exceedance for DABs this month.

Total number of DABs (April 2025 – date) = **64**

- Hospital acquired = **1**
  - Hickman Line (No attributed ward)

  There was no data exceedance for hospital acquired DABs this month.

- Healthcare acquired = **1**
  - Urinary catheter long term

  There was no data exceedance for healthcare acquired DABs this month.

- Nursing Home acquired = **0**
  There was no data exceedance for nursing home acquired DABs this month.

Hospital DABs

- **Hickman Line**; No ward attributed due to completed documentation.

Escherichia coli Bacteraemia (ECB)

NHS Forth Valley's approach to ECB prevention and reduction
E coli is one of the most predominant organisms of the gut flora and for the last several years the incidence of Ecoli isolated from blood cultures ie causing sepsis, has increase so much that it is the most frequently isolated organism in the UK. Following on from the 2019-2024 AOP targets, new targets are going to be set by the Scottish Government shortly. The most common cause of E coli bacteraemia (ECB) is from complications arising from urinary tract infections (UTIs), hepato-biliary infections (gall bladder infections) and urinary catheters infections.

Total number of ECBs this month - **10** compared to **6** last month.
There was no data exceedance for ECBs this month.

Total number of ECBs (April 2025 – date) = **122**

- Hospital acquired = **4**
    - Hepatobiliary x 2 (No attributed ward)
    - Unknown x 1 (No attributed ward)
    - Urinary tract infection x 1 (No attributed ward)

  There was no data exceedance for hospital acquired ECBs this month.

- Healthcare acquired = **4**
    - Urinary catheter long term x 1
    - Unknown x 1
    - Urinary tract infection x1
    - Congenital infection x 1

  There was no data exceedance for healthcare acquired ECBs this month.

- Nursing Home acquired = **2**
    - Hepatobiliary
    - Urinary tract infection
- There was no data exceedance for nursing home acquired ECBs this month.

Hospital ECBs

- **Hepatobiliary infection**;
    - patient developed post ERCP pancreatitis due to ongoing malignancy.
    - patient developed recurrent cholecystitis during hospital admission following admission with cholangitis
- **Urinary tract infection;** patient with known recurrent UTIs developed infection during admission.
- **Unknown**; following investigations no definitive source of infection was identified.

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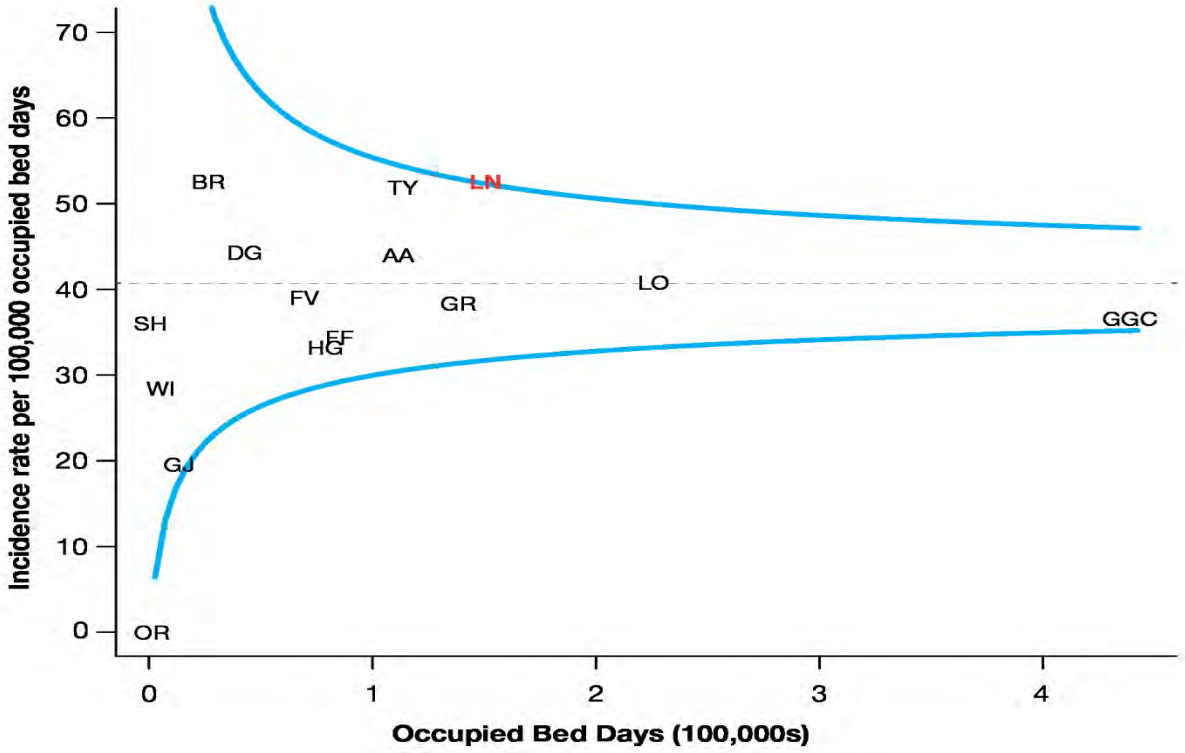
National Context

All ECBs are reported nationally and reported on a quarterly basis. This provides our board an overview and national context of our national position compared to other boards. Due to the national reporting, unfortunately the data published is 3 months in arrears compared to the local data presented. The funnel plot below contains total case numbers of reported hospital and healthcare attributed infections and provides an indication of FVs position nationally. Below is an extract from ARHAIs Quarter 4 report (October – December 2025) highlighting Forth Valley's position compared to all other boards in Scotland.



Clostridioides difficile infection (CDIs)

Following the Vale of Leven outbreak in 2007 where 131 patients were infected with C. difficile resulting in 34 deaths, it became mandatory for all health boards to monitor, investigate and report all infections associated with C. difficile. NHSFV has met its targets over the years and has maintained a low rate of infection.

C. difficile can be part of the normal gut flora and can occur when patients receive broad spectrum antibiotics which eliminate other gut flora allowing C. difficile to proliferate and cause infection. This is the predominant source of infection in Forth Valley. C. difficile in the environment can form resilient spores which enable the organism to survive in the environment for many months and poor environmental cleaning or poor hand hygiene can lead to the organism transferring to other patients leading to infection (as what happened in the Vale of Leven hospital). Another route of infection is when patient receive treatment to regulate stomach acid which affects the overall pH of the gut allowing the organism to proliferate and cause infection.

Cause definitions for Clostridioides difficile infections

Hospital acquired

- Hospital acquired is defined when symptoms develop and confirmed by the laboratory >48 hours after admission which were not associated with the initial cause of admission.

Healthcare acquired

- Healthcare acquired is defined as having symptoms that develop and confirmed by the laboratory prior to or within 48 hours of admission and has in the last three months had healthcare interventions such as previous hospital admission, attending Clinics, GP, dentist etc.

Nursing home acquired

- Nursing home acquired is defined as having symptoms that develop and confirmed by the laboratory that developed at the nursing home prior to admission.

GP acquired

- GP associated CDI infections are not required to be reported nationally, however, locally it is considered important to monitor and report infections deriving from GP practices. All CDI infections from GPs are reviewed and investigated to the same standard as hospital infections to determine the cause of infection. In addition, data is shared with the Antimicrobial Management Group to allow the group to monitor overall antibiotic prescribing trends for individual GP practices.

NHS Forth Valley's approach to CDI prevention and reduction

Similar to our SABs and DABs investigation, patient history is gathered including any antibiotics prescribed over the last few months. Discussion with the clinical teams and microbiologists assist in the determination and conclusion of the significance of the organism, as sometimes the organism isolated can be an incidental finding and not the cause of infection. Data is shared with the antimicrobial pharmacist and cases are discussed at the Antimicrobial Management Group to identify inappropriate antimicrobial prescribing.

Total number of CDIs this month; **4** compared to **3** last month.
There was no data exceedance for CDIs this month.

Total number of CDIs (April 2025 – date) = **32**

- Hospital acquired = **1**
  There was no data exceedance for hospital acquired CDIs this month.

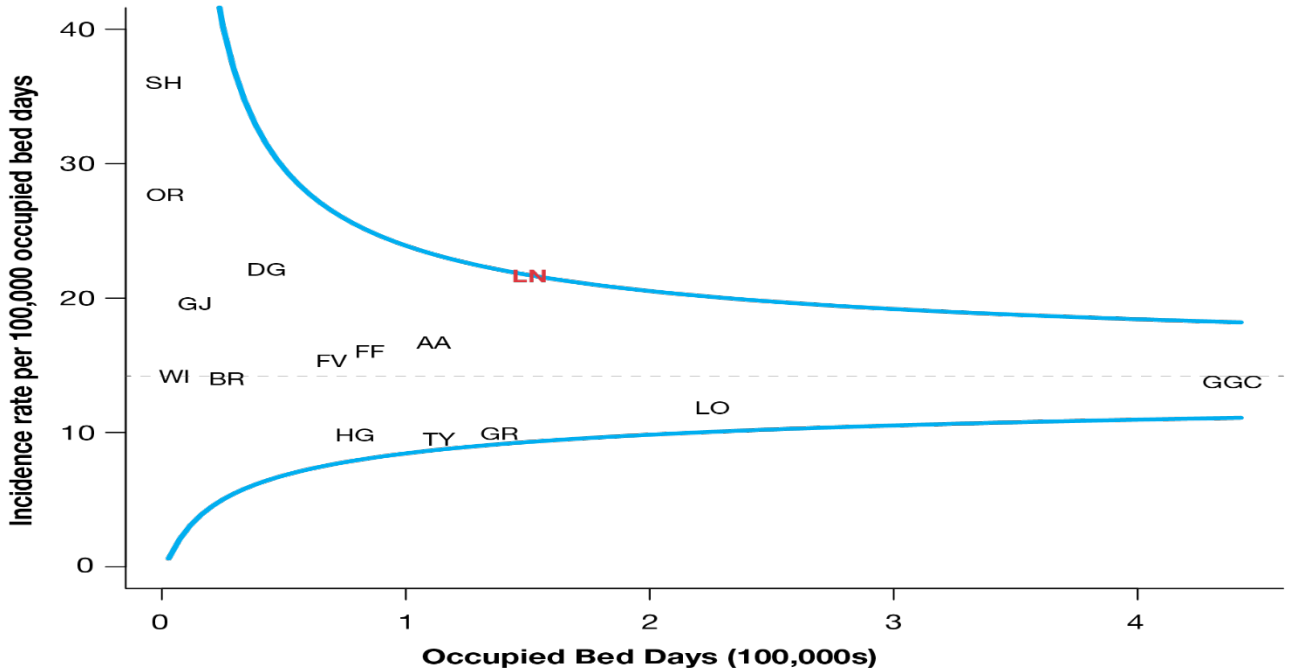
- Healthcare acquired = **3**
  There was no data exceedance for healthcare acquired CDIs this month.

- Nursing Home acquired = **0**
  There was no data exceedance for nursing home acquired CDIs this month.

- GP acquired = **1**
  (GP figures are not included in the total as it is not part of national reporting)

National Context

All CDIs are reported nationally and reported on a quarterly basis. This provides our board an overview and national context of our national position compared to other boards. Due to the national reporting, unfortunately the data published is 3 months in arrears compared to the local data presented. The funnel plots below are based on the new national AOP targets ie hospital and healthcare are represented as healthcare and provides an indication of FVs position nationally. Below is an extract from the ARHAI Quarter 4 report (October – December 2025) highlighting Forth Valley's position compared to all other boards in Scotland.



Surgical Site Infection Surveillance (SSIS)

Surgical site infection surveillance is the monitoring and detection of infections associated with a surgical procedure. In Forth Valley, the procedures include, hip arthroplasty, Caesarean section, abdominal hysterectomy, major vascular surgery, large bowel, knee arthroplasty and breast surgeries. We monitor patients for 30 days post-surgery including any microbiological investigations from the ward/GP for potential infections and also hospital readmissions relating to their surgery. Any infection associated with a surgical procedure is reported nationally to enable board to board comparison. The NHS Forth Valley infection rates are comparable to national infection rates.

NHS Forth Valley's approach to SSI prevention and reduction

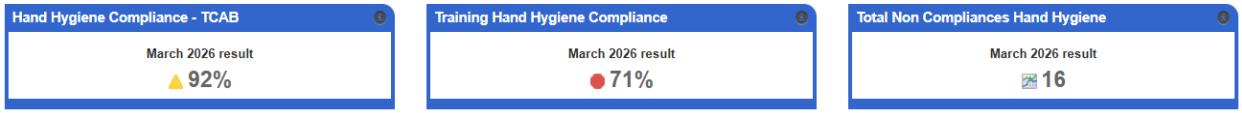
Surgical site infection criteria is determined using the European Centre for Disease Control (ECDC) definitions. Any infection identified is investigated fully and information gathered including the patient's weight, duration of surgery, grade of surgeon, antibiotics given, theatre room, elective or emergency etc can provide additional intelligence in reduction strategies. The IPCT monitor closely infection rates, and any increases of SSIs are reported to management and clinical teams to enable collaborative working to reduce infection rates. The table below also contains local surveillance with an extended surveillance period of 90 days.

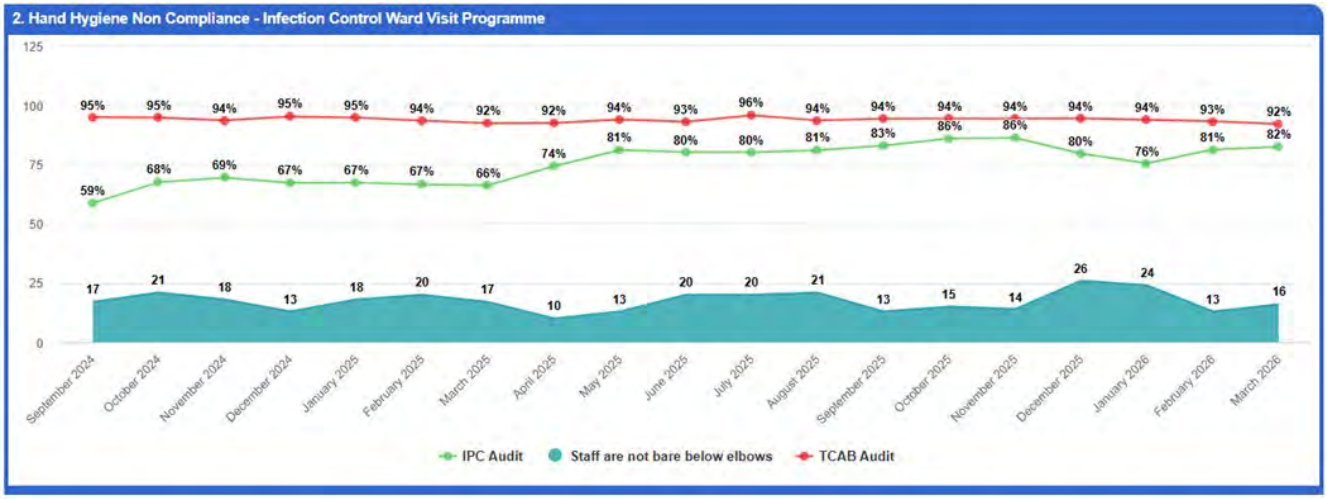
Procedure	**No of Procedures this month**	**No. of Confirmed SSIs this month (Mandatory 30 days)**	**No. of Confirmed SSIs this month (Local 90 days)**
Abdominal Hysterectomy	15	0	0
Breast Surgery	42	0	0
Caesarean Section	91	0	0
Hip Arthroplasty	74	0	0
Knee Arthroplasty	47	0	0
Large Bowel Surgery	11	0	0

Hand Hygiene Monitoring Compliance (%) Board wide

The data below is an extract from the Pentana dashboard. It includes the total percentage of compliance that is recorded on TCAB by the nursing staff. It also includes the uptake of staff who have completed the hand hygiene training module in Turas along with the total number of hand hygiene non compliances that are recorded in the Infection Prevention and Control team SICP audits.

The recent decline in Hand hygiene compliance was discussed at the Infection Control Committee and an action plan has been implemented to further improve our compliance rates.





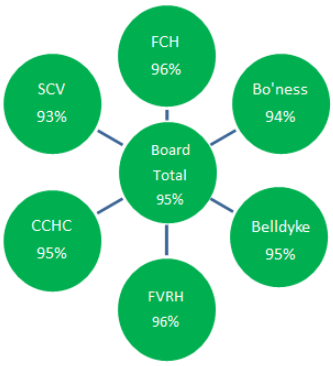
Estate and Cleaning Compliance (per hospital)

The data is collected through audit by the Domestic Services team using the Domestic Monitoring National Tool and areas chosen within each hospital is randomly selected by the audit tool. Any issues such as inadequate cleaning is scored appropriately and if the score is less than 80% then a re-audit is scheduled. Estates compliance is assessed whether the environment can be effectively cleaned; this can be a combination of minor non-compliances such as missing screwcaps, damaged sanitary sealant, scratches to woodwork etc. The results of these findings are shared with Serco/Estates for repair. Similar to the cleaning audit, scores below 80% triggers a re-audit.

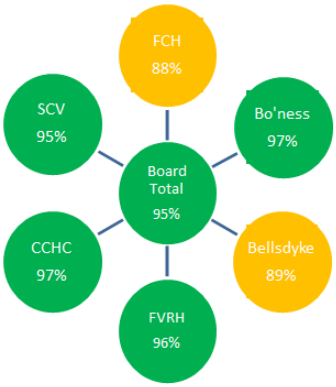
Falkirk Community Hospital and Bellsdyke Hospital Estate Scores

This quarter, the estate scores have remained relatively stable, Falkirk Community Hospital and Bellsdyke Hospital scores have decreased this quarter. Falkirk Community hospital is 88% compared to 89% the previous quarter and Bellsdyke is 89% compared to 91% the previous quarter.

Estates & Domestic Cleaning Scores from Cleaning Dashboard January – March 2026



Cleaning Compliance



Estates Compliance

Colour		Description
	Green	compliance level 90% and above - Compliant
	Amber	compliance level between 70% and 90% - Partially compliant
	Red	compliance level below 70% - Non-compliant

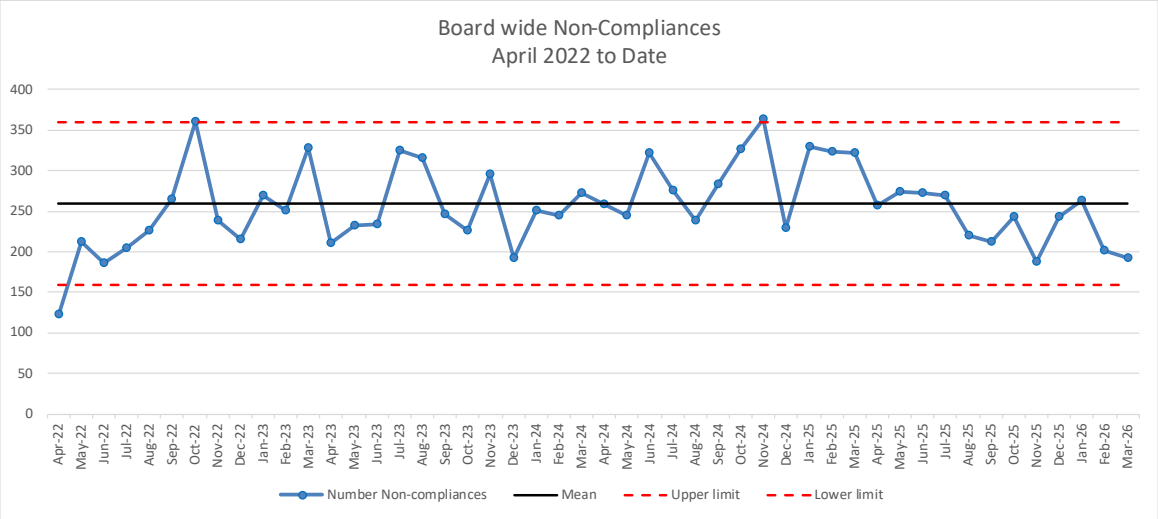
Ward Visit Programme

The purpose of these audits is to assess compliance to standard infection control precautions (SICPs); each aspect or SICP can be contributary factors to infection. All non-compliances are fed back to the nurse in charge immediately following the ward visit. A follow-up email is also sent to the ward and service manager. Details of each non-compliance are reported in the monthly HAI Service Reports and are discussed at the local Infection Control meetings.

The predominant non-compliance categories reported were Managing Patient Care Equipment category; non-compliances included equipment visibly dirty, items stored inappropriately, indicator tape/label missing. Control of the Environment, non-compliances included, area is not well maintained and in good state of repair, all stores are not above floor level and inappropriate items in clinical area. Non-compliances have decreased this month from 201 to 192 non-compliances.

All non-compliances were highlighted to the nurse in charge at the time of audit and any equipment with cleanliness issues was rectified immediately.

Below is an SPC chart detailing the non-compliances identified during the ward visits. A further breakdown of non-compliances is detailed in the appendix of this report.



Incidence / Outbreaks

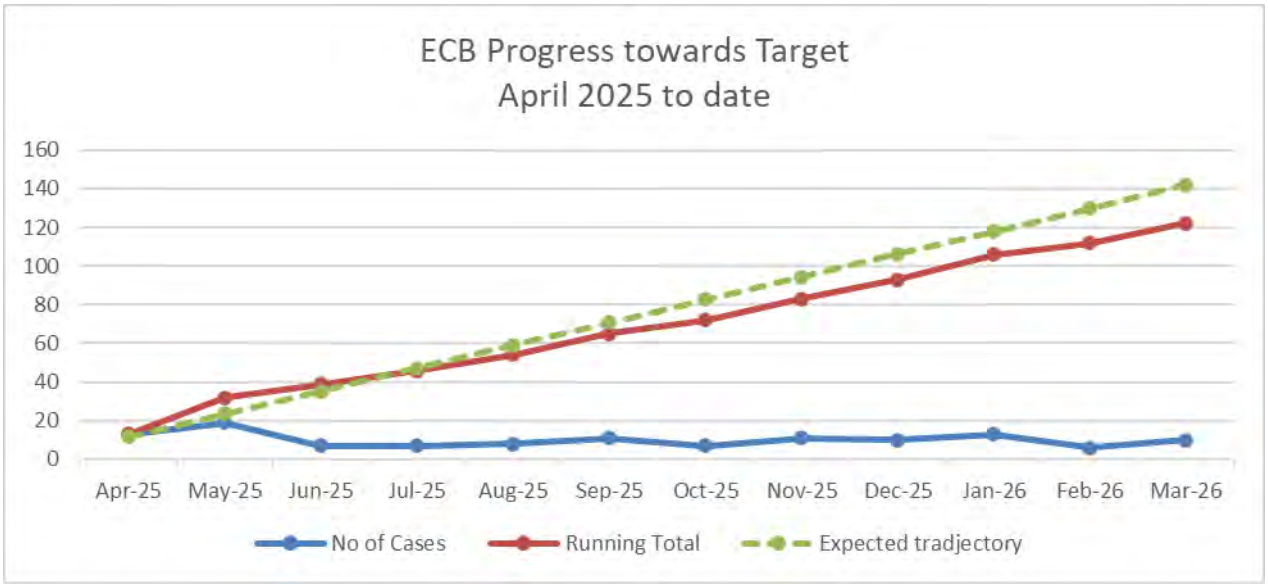
All outbreaks are notified to Health Protection Scotland and Scottish Government (see below for further details).

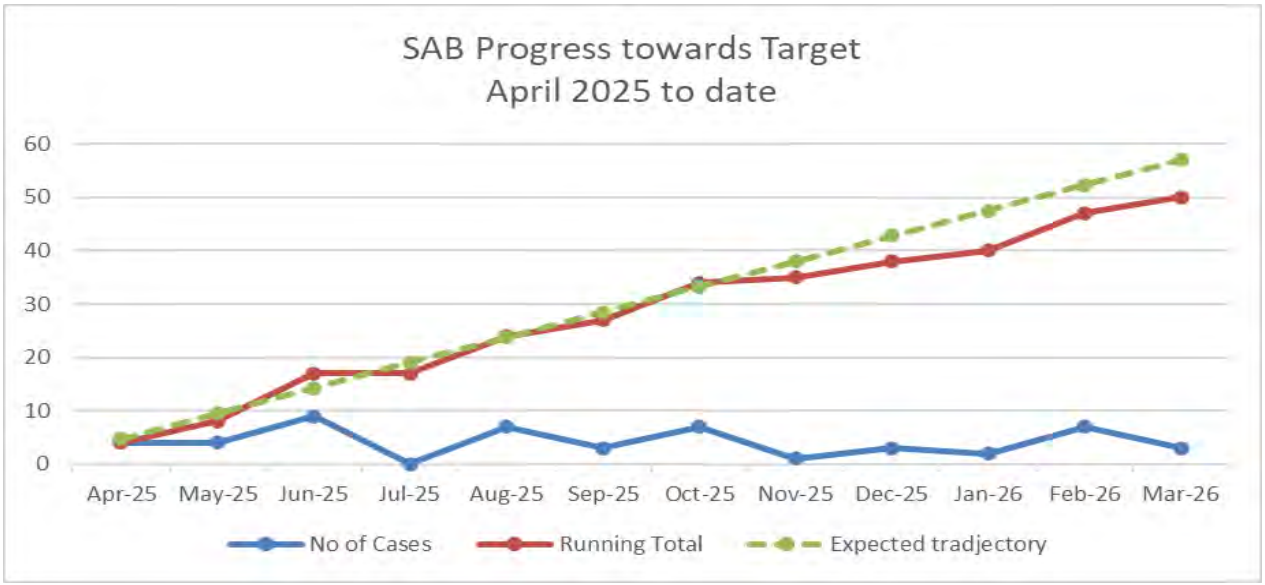
<u>Healthcare Acquired Infection Incident Template (HAIIT)</u>
The HAIIT is a tool used by boards to assess the impact of an incident or outbreak. The tool is a risk assessment and allows boards to rate the incident/outbreak as a red, amber, or green. The tool also directs boards whether to inform ARHAI Scotland/SG of the incident (if amber or red), release a media statement etc.

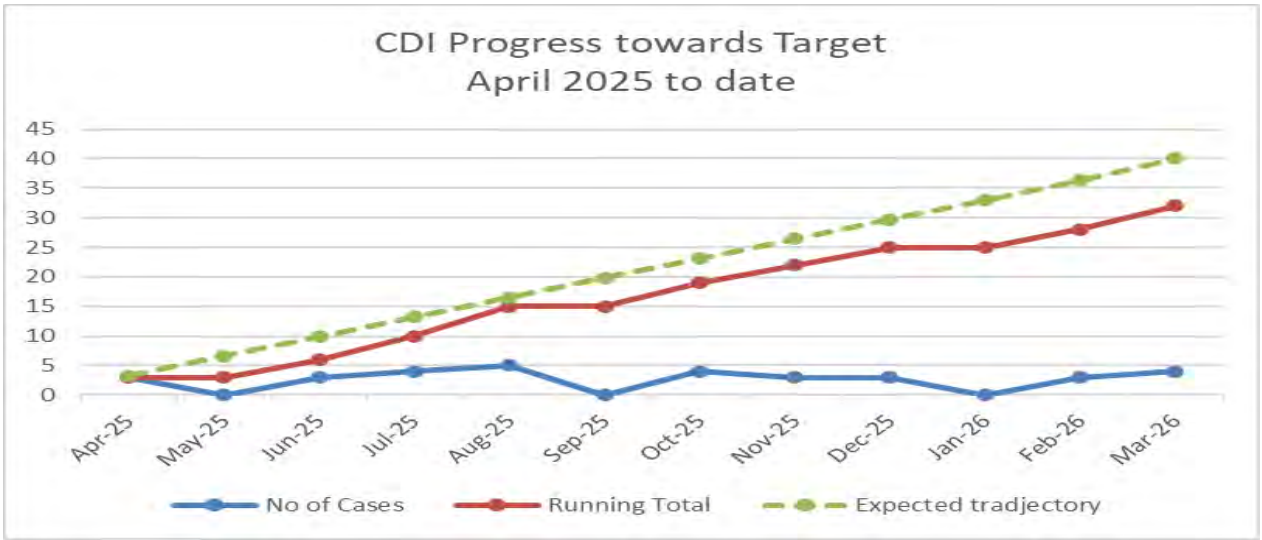
There was one outbreak reported this month:

Month	Ward	Type of Outbreak	No of patients affected
Mar-26	Ward A22, FVRH	Norovirus	13

LDP Targets

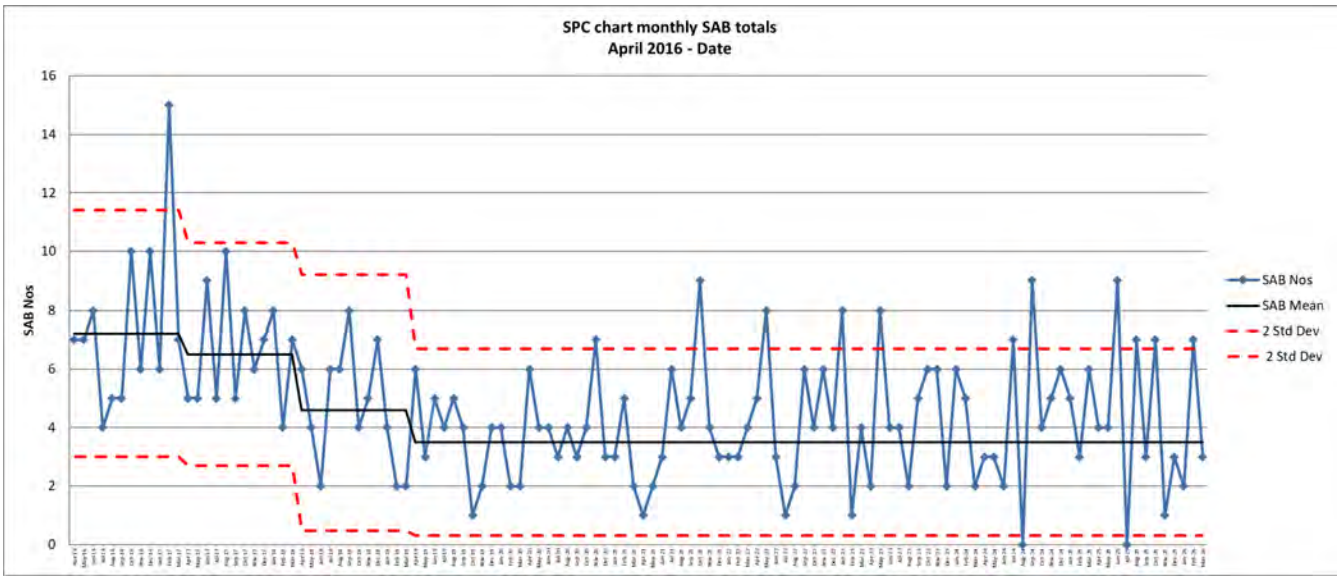

ECB Progress towards Target
April 2025 to date
160
140
120
100
80
60
40
20
0
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
No of Cases
Running Total
Expected tradjectory

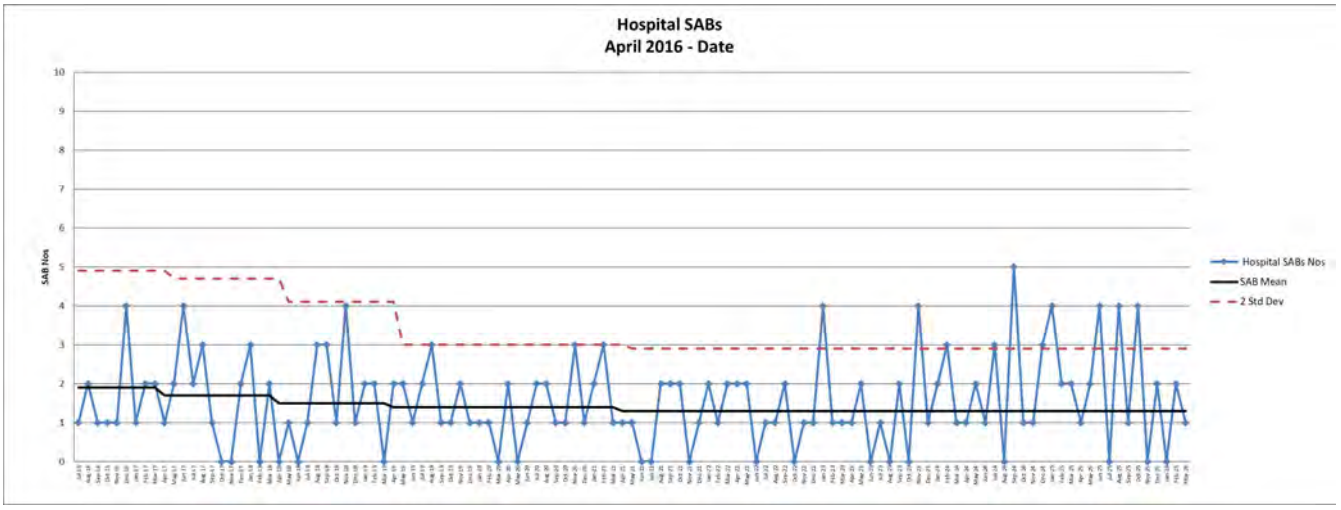

SAB Progress towards Target
April 2025 to date
60
50
40
30
20
10
0
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
No of Cases
Running Total
Expected tradjectory

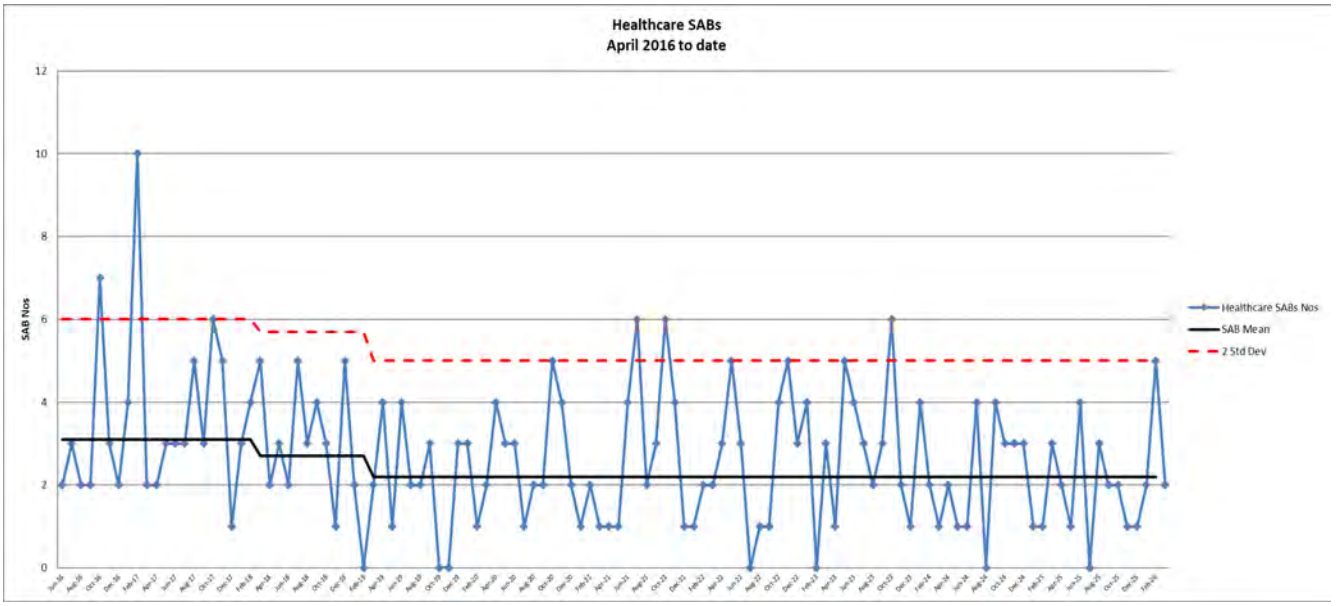

CDI Progress towards Target
April 2025 to date
45
40
35
30
25
20
15
10
5
0
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
No of Cases
Running Total
Expected tradjectory

HAI Surveillance Statistical Processing Charts

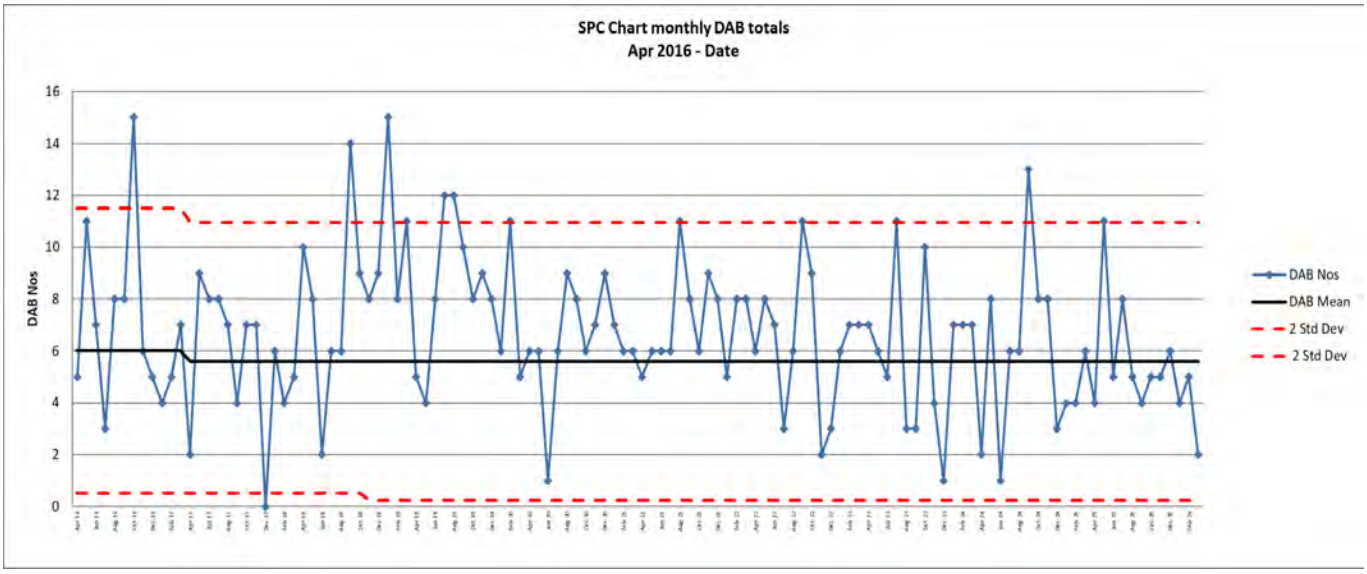
Staphylococcus aureus Bacteraemias (SABs)

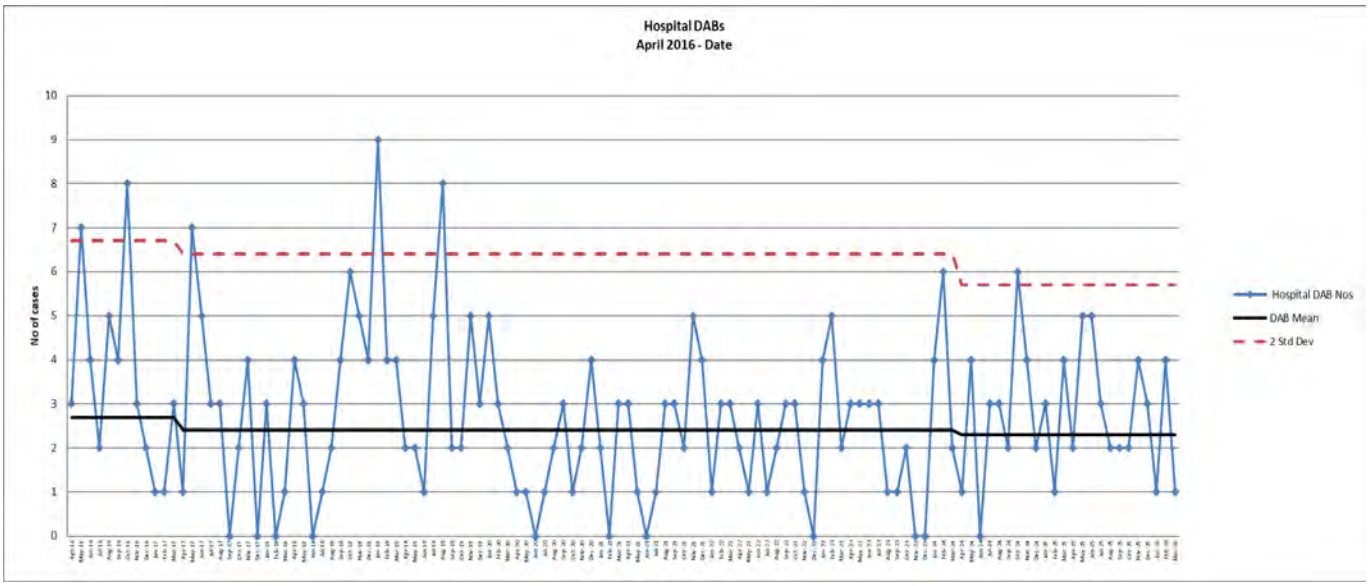


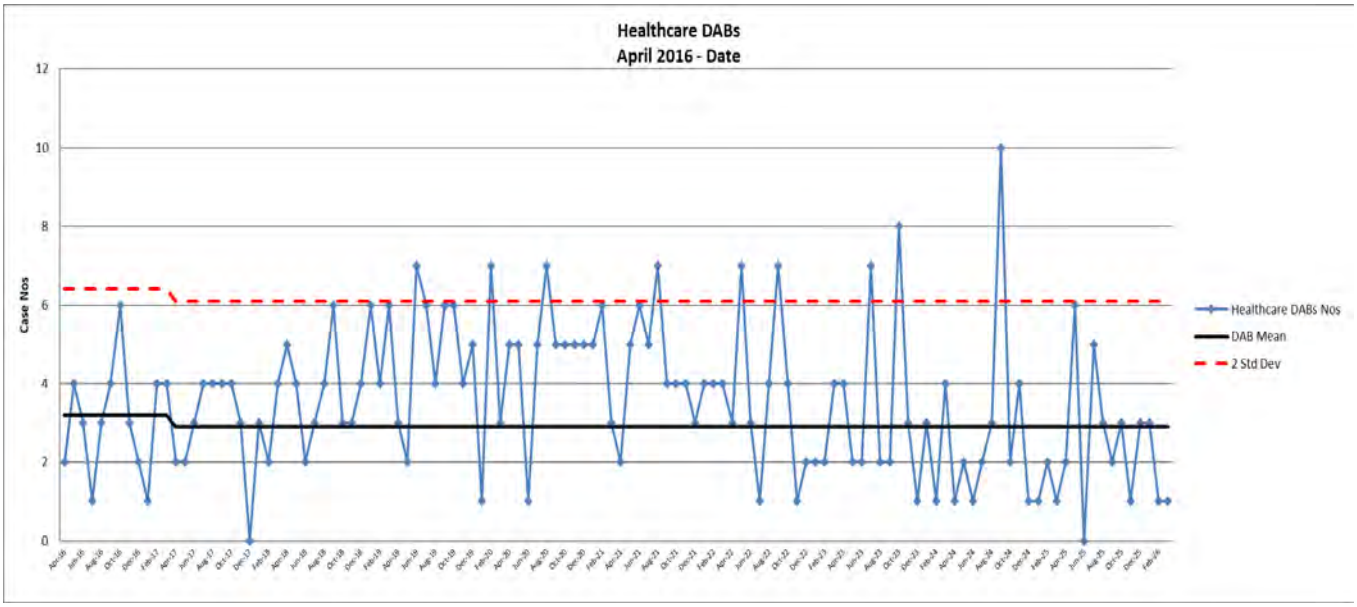




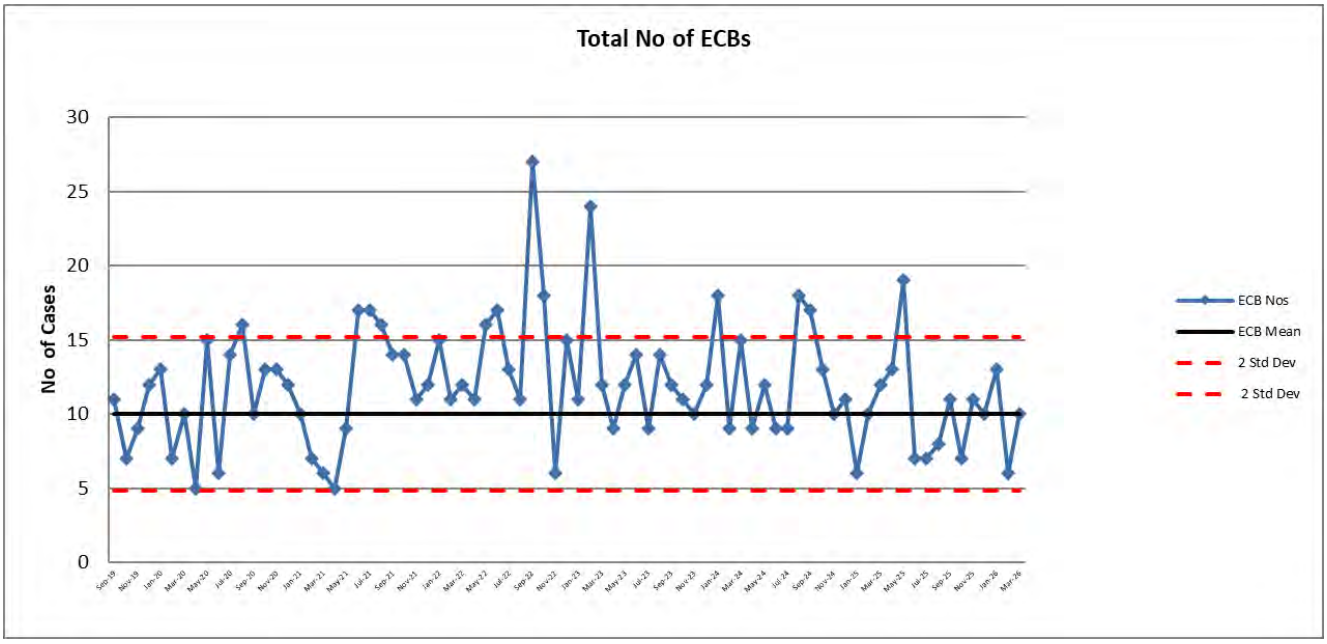
Device Associated Bacteraemias (DABs)

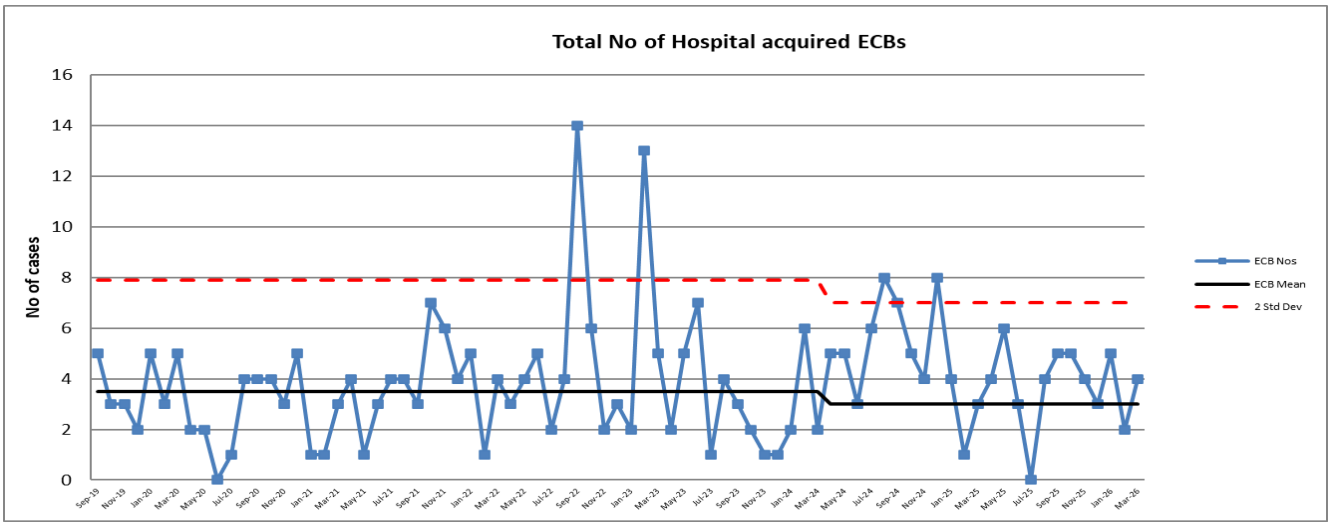


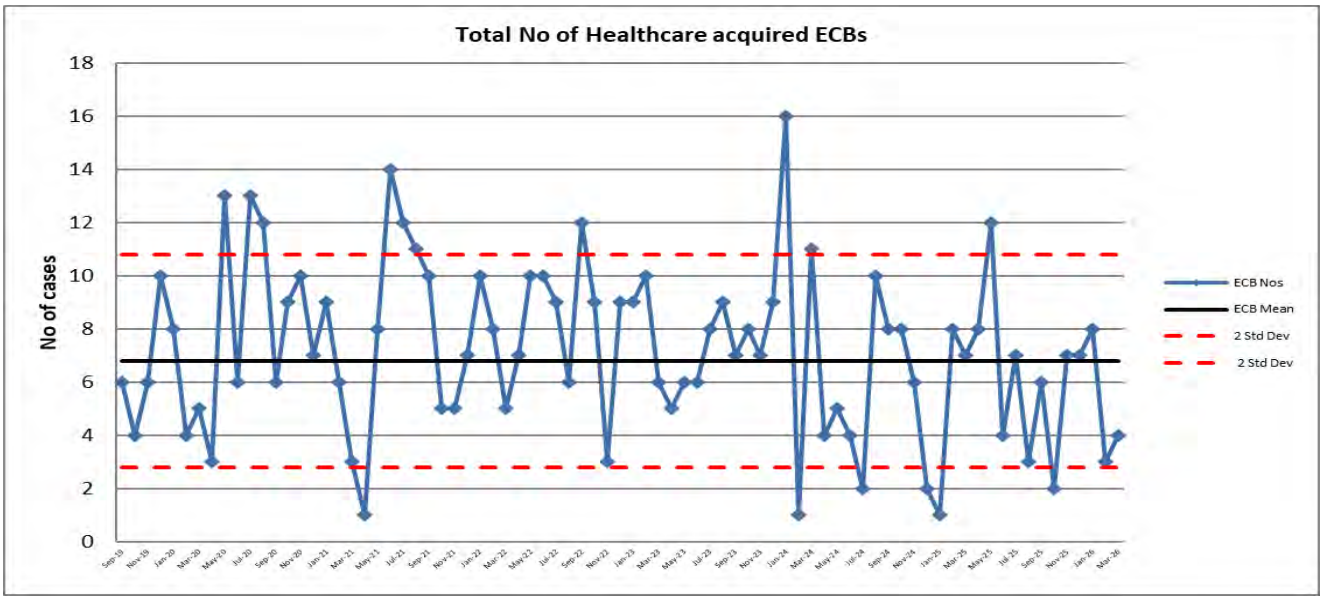




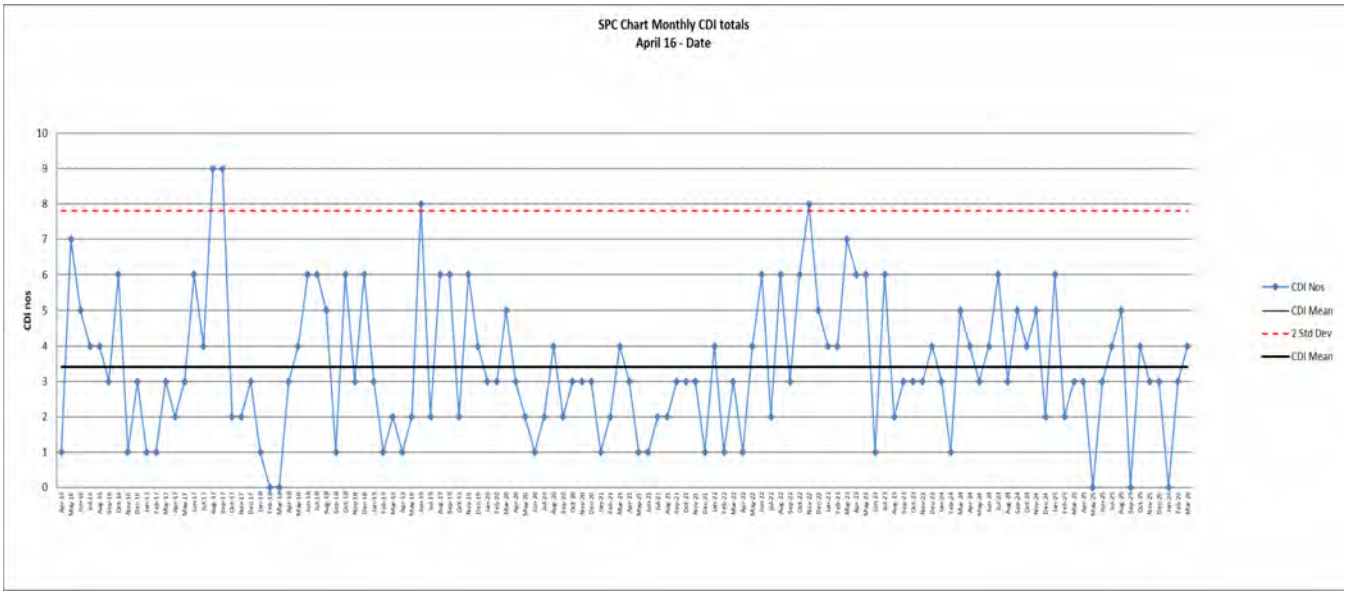
Escherichia coli Bacteraemias (ECBs)

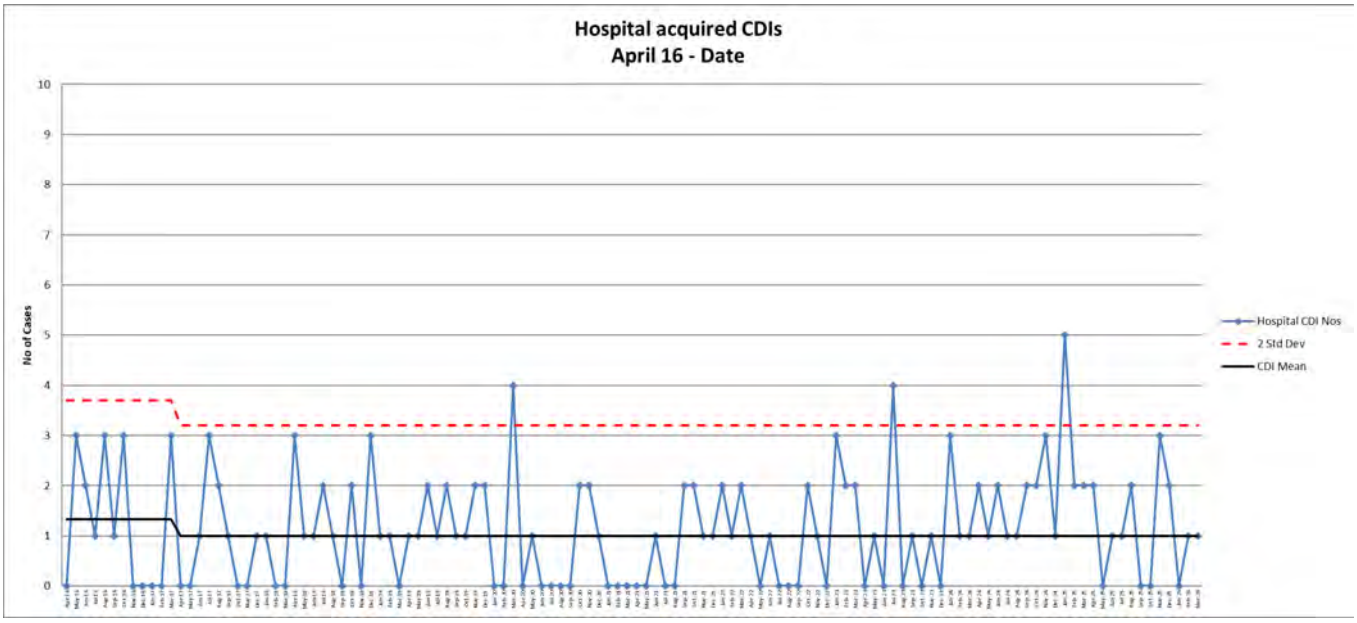


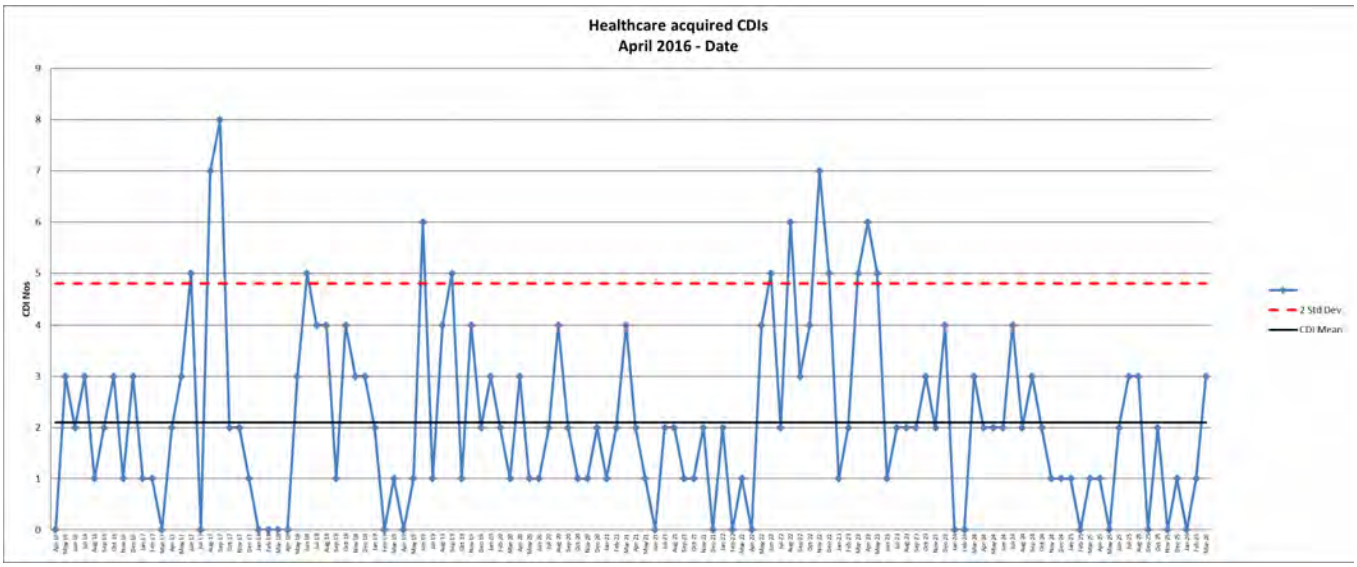




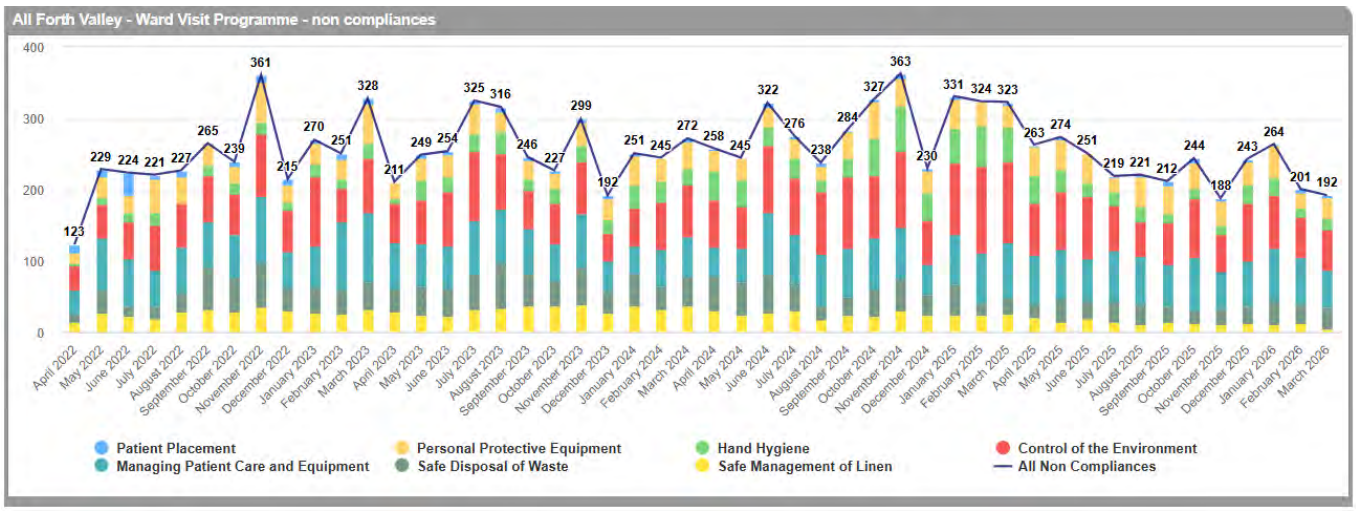
Clostridioides difficile Infections (CDIs)

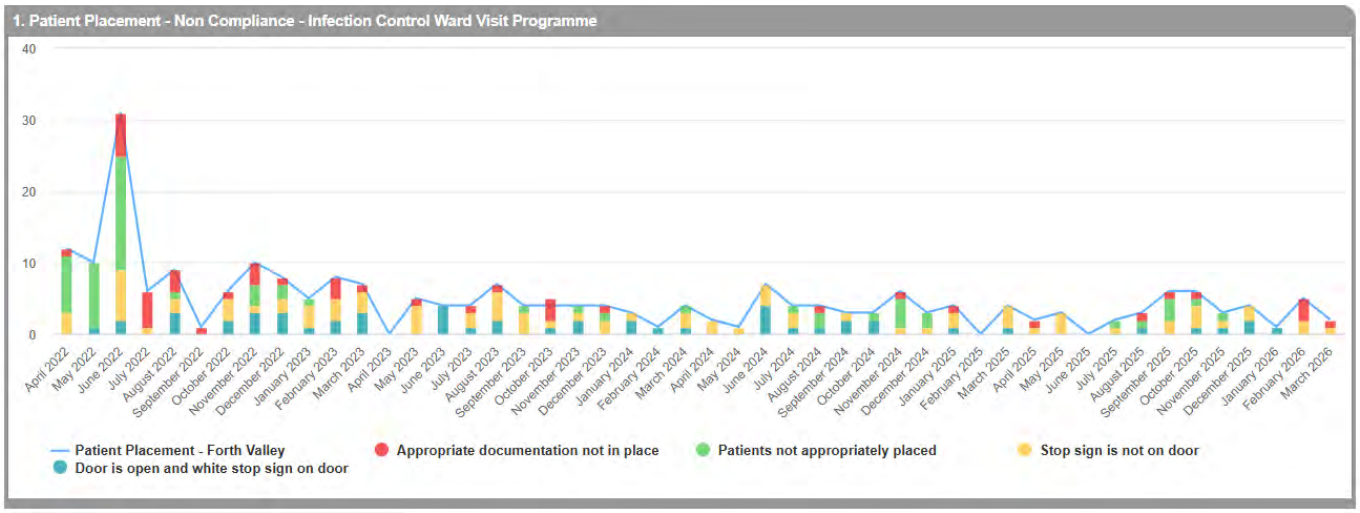


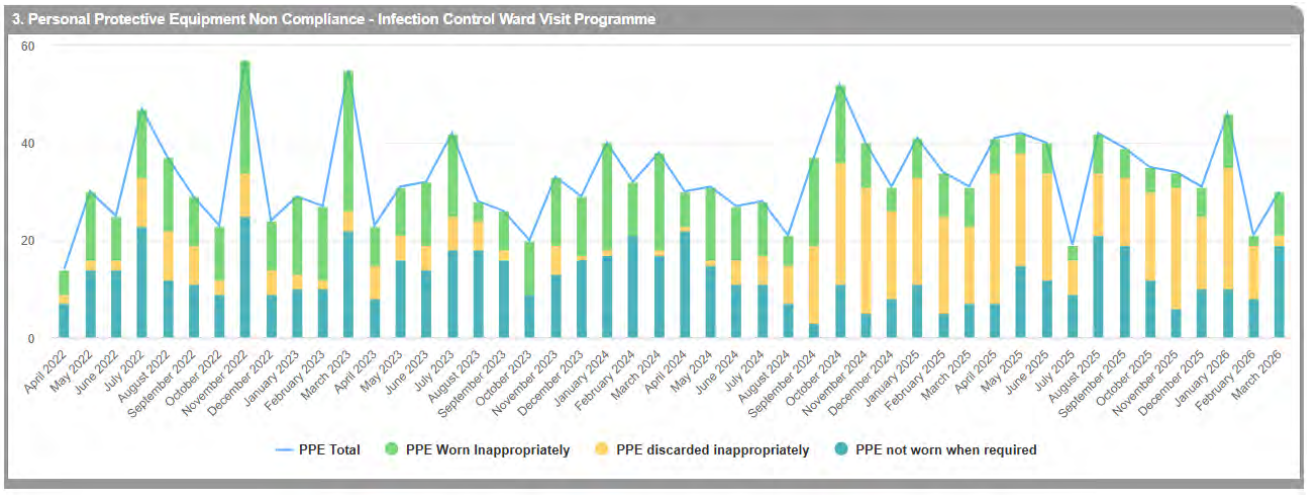


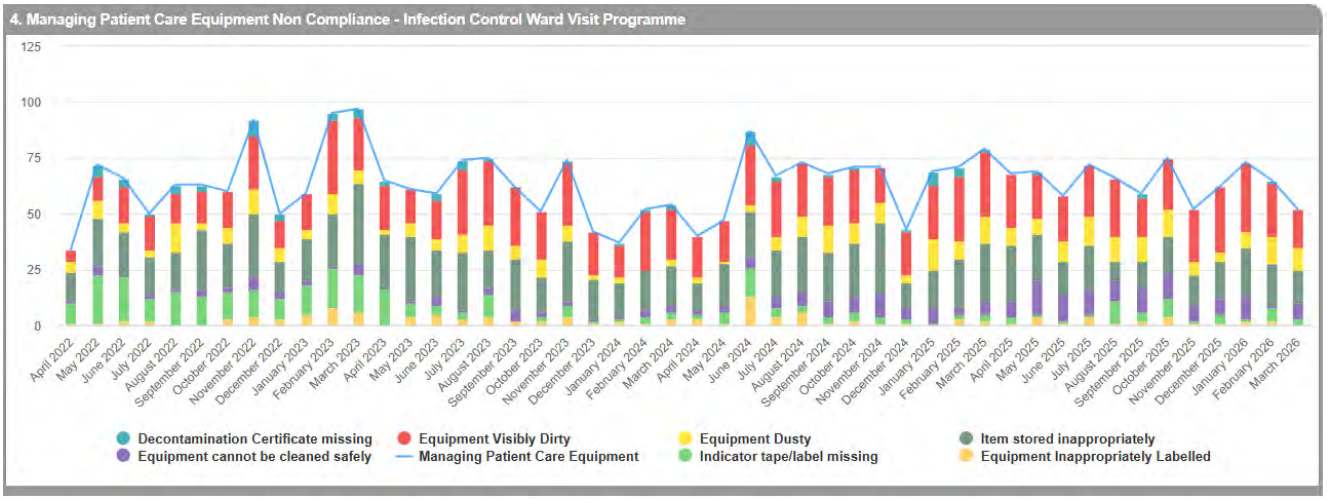


Ward Visit Non-Compliances by SICP


All Forth Valley - Ward Visit Programme - non compliances
Patient Placement
Managing Patient Care and Equipment
Personal Protective Equipment
Safe Disposal of Waste
Hand Hygiene
Safe Management of Linen
Control of the Environment
All Non Compliances


1. Patient Placement - Non Compliance - Infection Control Ward Visit Programme
Patient Placement - Forth Valley
Door is open and white stop sign on door
Appropriate documentation not in place
Patients not appropriately placed
Stop sign is not on door


3. Personal Protective Equipment Non Compliance - Infection Control Ward Visit Programme
PPE Total
PPE Worn Inappropriately
PPE discarded inappropriately
PPE not worn when required


4. Managing Patient Care Equipment Non Compliance - Infection Control Ward Visit Programme
125
100
75
50
25
0
April 2022
May 2022
June 2022
July 2022
August 2022
September 2022
October 2022
November 2022
December 2022
January 2023
February 2023
March 2023
April 2023
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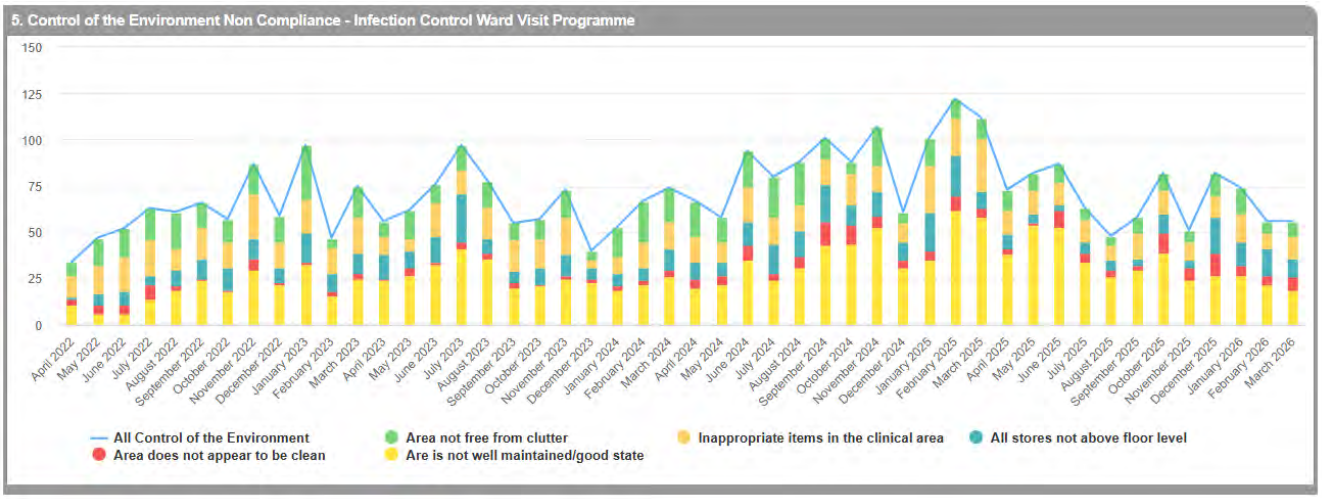
February 2025
March 2025
April 2025
May 2025
June 2025
July 2025
August 2025
September 2025
October 2025
November 2025
December 2025
January 2026
February 2026
March 2026
Decontamination Certificate missing
Equipment Visibly Dirty
Equipment Dusty
Item stored inappropriately
Equipment cannot be cleaned safely
Managing Patient Care Equipment
Indicator tape/label missing
Equipment Inappropriately Labelled


5. Control of the Environment Non Compliance - Infection Control Ward Visit Programme
150
125
100
75
50
25
0
April 2022
May 2022
June 2022
July 2022
August 2022
September 2022
October 2022
November 2022
December 2022
January 2023
February 2023
March 2023
April 2023
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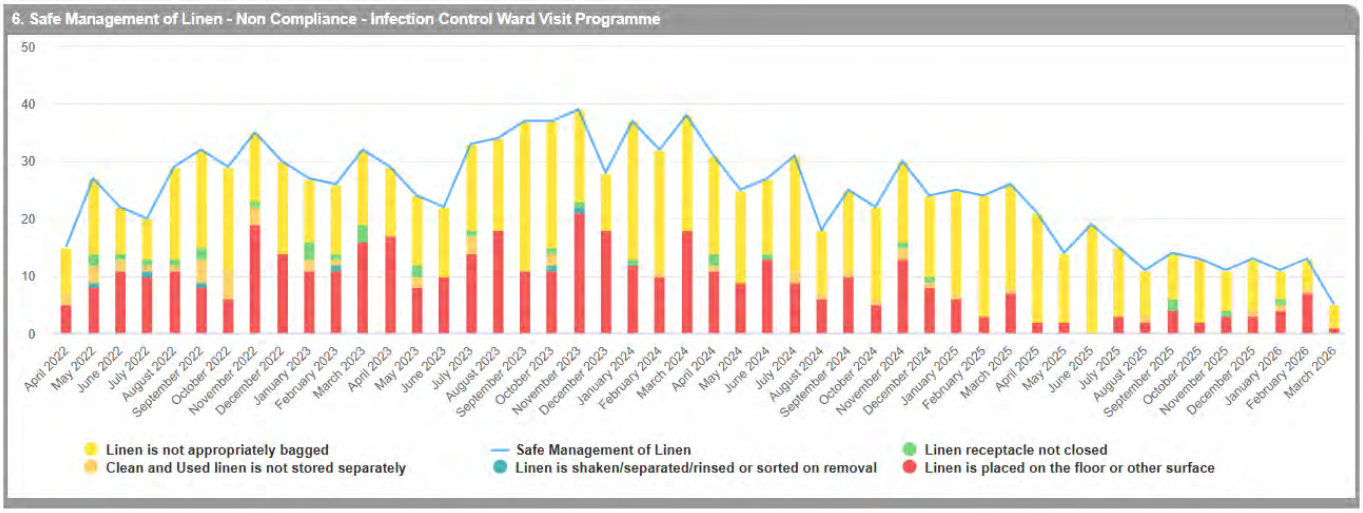
February 2025
March 2025
April 2025
May 2025
June 2025
July 2025
August 2025
September 2025
October 2025
November 2025
December 2025
January 2026
February 2026
March 2026
All Control of the Environment
Area not free from clutter
Inappropriate items in the clinical area
All stores not above floor level
Area does not appear to be clean
Are is not well maintained/good state


6. Safe Management of Linen - Non Compliance - Infection Control Ward Visit Programme
50
40
30
20
10
0
April 2022
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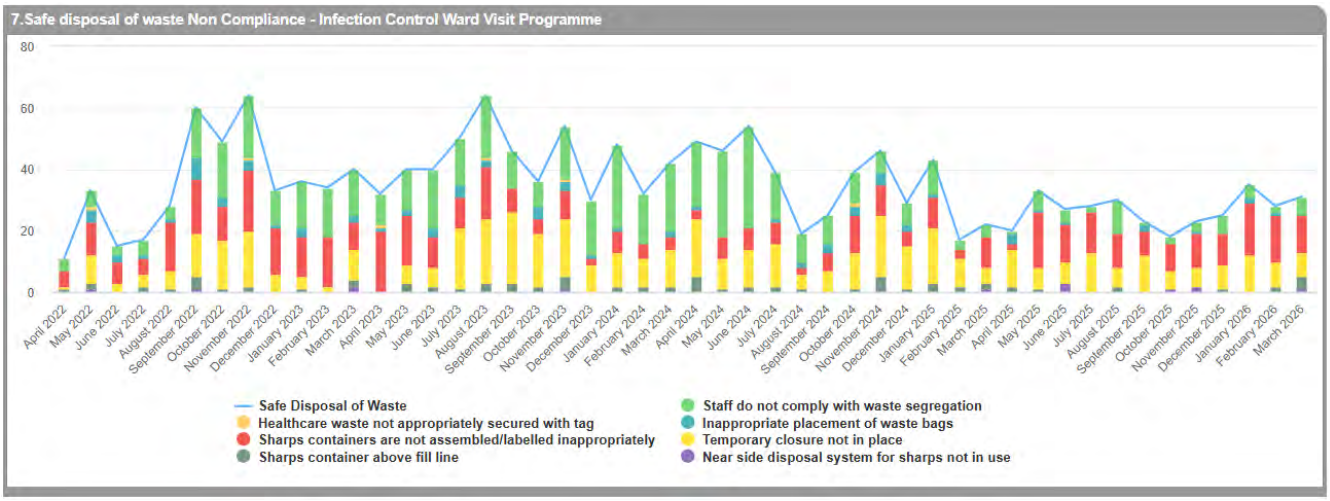
Linen is not appropriately bagged
Safe Management of Linen
Linen receptacle not closed
Clean and Used linen is not stored separately
Linen is shaken/separated/rinsed or sorted on removal
Linen is placed on the floor or other surface


7.Safe disposal of waste Non Compliance - Infection Control Ward Visit Programme
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Safe Disposal of Waste
Healthcare waste not appropriately secured with tag
Sharps containers are not assembled/labelled inappropriately
Sharps container above fill line
Staff do not comply with waste segregation
Inappropriate placement of waste bags
Temporary closure not in place
Near side disposal system for sharps not in use

NHS Forth Valley
Forth Valley NHS Board

13. Health and Care (Staffing) (Scotland) Act 2019 Annual Report
Purpose: This report is for Decision

Executive Sponsor: Karen Goudie, Executive Nurse Director
Author: Katrina Robertson, HR Nursing Workforce Lead Nurse

Executive Summary

The purpose of this paper is to seek Board approval for the publication of NHS Forth Valley's Year 2 Annual Report under the Health and Care (Staffing) (Scotland) Act 2019 (HCSSA), covering the period April 2025 to March 2026.

The report at Appendix 1 provides the statutory annual assurance required by the Act and sets out how NHS Forth Valley has discharged its duties under sections 12IA, 12IC, 12ID, 12IE, 12IF, 12IH, 12II, 12IJ and 12IL. It reflects system-wide activity across all professions and Healthcare staff in scope of the act and demonstrates how staffing information has been used to inform workforce planning, risk management and service improvement.

The report confirms that NHS Forth Valley has assessed its overall level of compliance with the Act as 'Reasonable Assurance', with areas of 'Substantial Assurance' identified for several individual duties, including real-time staffing assessment, risk escalation processes and application of the Common Staffing Method. It also transparently outlines areas of challenge and ongoing improvement, particularly in relation to workforce availability, training compliance, system implementation consistency and medical staffing sustainability.

In line with statutory requirements, the report will be submitted to the Scottish Government and the Patient Safety Commissioner. It also requires to be published on the NHS Forth Valley website following Board approval. Publication supports transparency, public accountability and national collation of Health Board reports for presentation to the Scottish Parliament.

Action Required

The Forth Valley NHS Board is asked to:

(1) approve the NHS Forth Valley Health and Care (Staffing) (Scotland) Act Annual Report 2025–26 for publication;
(2) note the overall assurance position of Reasonable Assurance and the identified priorities for continued improvement during the next reporting period, and
(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

The information contained within this report has been collated from all professional groups in scope of the HCSSA and associated statutory guidance and is presented for approval and publication.

All safe staffing governance and assurance are undertaken at local service and directorate level through established workforce governance arrangements, where

staffing data, professional judgement, risks and mitigating actions are routinely reviewed and agreed. This local assurance process ensures compliance with safe staffing duties prior to escalation through the workforce governance structure and onward to Board-level scrutiny, providing confidence in the robustness of the assurance presented within this report.

Risk Assessment and Mitigation

The implementation of the HCSSA during the next reporting period will take place in the context of sustained operational pressure, ongoing workforce constraints and continued transition to digital staffing systems. While NHS Forth Valley has established governance, escalation and assurance arrangements, the following key risks are anticipated in 2026–27 and will require continued executive and Board oversight.

The overall assurance position remains Reasonable Assurance, reflecting a sound framework of governance and control, with some areas requiring continued focus to support sustainability and consistency as the Act becomes fully embedded into business as usual.

Key Risks & Mitigations

Key Risk	Potential Impact	Mitigation / Control
Workforce availability and sustainability,	Increased reliance on locum or supplementary staffing, reduced continuity of care, staff fatigue and pressure on service sustainability	Ongoing workforce planning, blueprinting and use of the Common Staffing Method; targeted recruitment and retention initiatives; development pathways including HCSW roles; clear escalation of persistent or severe risks through workforce and clinical governance to Board level where required
Affordability of staffing models as HCSSA arrangements move into business as usual	Constraint on ability to sustain staffing establishments identified as necessary through statutory tools and professional judgement	Alignment of workforce planning with financial planning and service redesign; prioritisation informed by staffing tools and real-time data; regional and national engagement on funding pressures associated with statutory staffing duties
Variation in adoption and maturity of digital staffing systems (eRostering,	Inconsistent real-time visibility of staffing risks and mitigation actions; reliance on interim manual processes	Phased and prioritised rollout plans focusing on higher-risk services; interim compliant arrangements with clear SOPs; targeted training and governance oversight to improve consistency and data quality

Safecare, Pentana)		
Operational pressure impacting protected leadership and learning time for clinical leaders	Reduced capacity for supervision, workforce management, escalation and staff development; potential impact on statutory compliance	Job planning and eRostering to define and monitor protected time; local mitigation and escalation where leadership time is consistently eroded; review through professional and workforce governance structures
Variable engagement and confidence as new tools and processes are embedded	Inconsistent application of statutory duties across services; risk of reduced staff confidence or engagement	Ongoing training and communication tailored to professional groups; use of staff feedback, iMatter results and governance forums to identify areas requiring additional support; continued emphasis on psychological safety and staff voice
Medical workforce pressures and rota compliance challenges	Increased financial risk, service disruption and wellbeing impacts for resident and senior medical staff	Strengthened medical workforce governance; Natural Break Enabling Group; contract and rota redesign work; escalation of recurrent or unmitigated risks through executive and Board governance

Summary Risk Position
NHS Forth Valley enters 2026–27 with mature governance and assurance arrangements in place for the Health and Care (Staffing) (Scotland) Act. However, workforce sustainability, affordability, digital system maturity and leadership capacity remain the most significant strategic risks for the coming year. These risks will continue to be monitored through existing governance structures, with escalation to the Board where risks are severe, recurrent or require strategic intervention.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty
Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial, Digital and Infrastructure Implications
There is a risk in relation to the outcomes of the implementation of the Act regarding some of the duties resulting in additional financial pressures. This risk is being articulated by the Directors of Finance on a local and national basis.

Progress continues with eRoster and Safecare rollout, with interim arrangements in place where required. Planned decommissioning of legacy systems remains on track, with transition work underway. SSTS will be decommissioned by March 2028 and work has already begun to ensure all areas are on eRoster and that the Staffing Level Tools make a transition over onto Safecare.

Workforce Implications
Ongoing review of workforce planning capacity is underway to ensure sufficient resources are available to sustain HCSSA requirements and future workforce needs.

Quality / Patient Care Implications
Safe staffing arrangements align with national and local quality assurance processes and support the delivery of safe, effective and person-centered care.

Population Health & Care Strategy
Delivery of the Health and Care (Staffing) (Scotland) Act supports the ambitions of NHS Forth Valley's Population Health and Care Strategy 2025–2035 by enabling workforce planning and staffing decisions that are informed by population need, professional judgement and service impact. HCSSA arrangements underpin prevention-focused and community-based models of care, support the delivery of more care closer to home, and help reduce health inequalities by directing workforce resource to areas of greatest need. The Act aligns with the principles of Realistic Medicine by promoting proportionate, evidence-based and person-centred decision-making, and supports Value Based Health & Care by ensuring staffing resources are prioritised toward activities that deliver the greatest benefit and outcomes for patients, communities and the workforce.

Climate Change / Sustainability Implications
Implementation of the HCSSA has indirect but positive implications for climate change and sustainability. Improved workforce planning, real-time staffing assessment and delivery of more care closer to home support more efficient use of resources, reduced duplication and avoidance of unnecessary hospital activity, which in turn can help reduce travel, waste and carbon impact. Continued rollout of digital systems, alongside service redesign and community-based models of care, aligns with wider NHS sustainability ambitions by supporting greener ways of working while maintaining safe, high-quality care.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☒ No ☐

Statutory engagement has been undertaken as part of the implementation and ongoing delivery of the HCSSA. Engagement has occurred through established professional, workforce and clinical governance arrangements, including involvement of clinical leaders, staff representatives, trade union partners and service management teams across all professional groups in scope of the Act. Staff views and professional judgement are routinely captured through local governance forums, workforce governance groups, surveys (including iMatter), and escalation and feedback processes associated with real-time staffing assessment. Communication and engagement will continue as part of business-as-usual arrangements, including feedback to staff on staffing decisions, risk mitigation actions and ongoing implementation of digital staffing tools, ensuring transparency and compliance with statutory requirements.

Appendices

Appendix 1 – Appendix 1 – Year 2 2025-26 Official FV Health and Care Staffing Act (HCSA) Report

HEALTH AND CARE (STAFFING) (SCOTLAND) ACT 2019 – NHS Forth Valley ANNUAL REPORT April 2025-March 2026

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Duty 12IJ: Duty to follow the common staffing method....61
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Report approval

1. The box below should be completed by the person signing off the report. An electronic signature is acceptable.
2. The Act requires the annual reports to be published by relevant organisations. Please enter a hyperlink to the webpage where the report can be found in the boxes below.

Name of organisation:	*NHS Forth Valley*
Report authorised by:	*Name*
	Designation
	Date
Location where report is published:	*[hyperlink]*

GUIDANCE ON USING THIS TEMPLATE

Purpose

This guidance has been developed to support relevant organisations in the completion of the below template which will form their annual report detailing compliance with the requirements of the Health and Care (Staffing) (Scotland) Act 2019 (the Act). Completed reports must be returned to hcsa@gov.scot by 30 April 2026.

Additional resources can be accessed here: Health and Care (Staffing) (Scotland) Act 2019: statutory guidance - gov.scot

If you require further assistance or have any queries, please contact hcsa@gov.scot.

Summary Section

3. The summary asks for an overview of how the relevant organisation has carried out all of the duties and requirements of the Act. This should include all NHS functions provided by all professional disciplines covered under the Act. You will be asked to provide an assurance level in respect of your overall compliance with the Act. Definitions for these assurance levels can be found at point seven.

4. Following receipt, the Scottish Ministers must collate reports from relevant organisations and lay a combined report before Parliament, along with an accompanying statement setting out how the information will be taken into account in policies for staffing of the health service. To enable this process, the information provided by relevant organisations should be comprehensive and pertinent to the staffing of the health service. To enable this, please complete the questions contained in the reporting template in sufficient detail, setting out the key achievements, outcomes, learning and risks and how this information has been used to inform workforce planning at the local level.

Individual duties / requirements

5. Following the summary section, the template seeks detail on individual duties/requirements of the Act in turn, asking relevant organisations to provide an assessment of compliance, and to provide details. Again, this should include all NHS functions, provided by all professional disciplines covered under the Act. Relevant organisations should provide detail to explain the assurance level in respect of the Duty, detailing evidence of compliance where appropriate, or gaps and areas of ongoing focus. Evidence could, for example, include details of the organisational structures, systems and/or processes being used.

6. The duty description contains the legislative wording of the Act, outlining the duty requirements.

7. As outlined at paragraph 3, the template requests an overall level of assurance with regard to the relevant organisation's compliance with the Act/Duties, using the assurance categories as detailed below:

Level of assurance	System adequacy	Controls
Substantial assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Controls are applied continuously or with only minor lapses.
Reasonable assurance	There is a generally sound system of governance, risk management, and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non- compliance.
Limited assurance	Significant gaps, weaknesses, or non- compliance were identified. Improvement is required to the system of governance, risk management, and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.
No assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.

8. The relevant organisation is asked to provide details of areas of success, achievement and learning associated with the particular duty or requirement, along with indicating how this could be used in the future. Again, in order to provide meaningful information that can inform healthcare staffing policy, relevant organisations are asked to complete this with an appropriate level of detail.

9. The relevant organisation is then asked to provide details of any areas of risk where they have been unable to achieve or maintain compliance with the particular duty or requirement, or where they have faced any challenges or risks in carrying out their duties or requirements. In this section, relevant organisations are also asked what actions have been or are being taken to address this. Again, in order to provide meaningful information that can inform healthcare staffing policy, relevant organisations are asked to provide an appropriate level of detail.

Summary

Please answer the following questions, to provide an overall assessment of how the organisation has carried out its duties under sections 12IA, 12IC, 12ID, 12IE, 12IF, 12IH, 12II, 12IJ and 12IL of the National Health Service (Scotland) Act 1978 (inserted by section 4 of the Act), and in line with Sections 1 and 2 of the Act : Guiding principles for health and care staffing and Guiding principles etc. in health and care staffing and planning.

Please advise how the information provided in this report has been used or will be used to inform workforce plans.
Summary on how the information within this report has/or will inform future workforce plans/planning. Examples include - but not limited to: 1. Impacts and outcomes of real -time staffing assessment on workforce/workload planning 2. How the outputs of the Staffing Level Tools and the application of the CSM have informed you workforce planning activity. 3. Impact of the Health and Care Staffing Act has led to safe and efficient staffing.
The information provided in this report is central to shaping workforce plans in NHS Forth Valley. By systematically analysing data, engaging staff and service users, and embedding robust governance and risk management processes, NHS Forth Valley can make evidence-based decisions that improve both patient and staff outcomes. Ongoing challenges are being addressed through targeted actions, continuous improvement, and the phased implementation of new systems and processes. **1. Real-Time Staffing Assessment: Impact on Workforce and Workload Planning** **Evidence:** • The implementation of eRostering and Safecare systems has enabled real-time assessment of staffing levels, skill mix, and training requirements across inpatient and other areas. • Twice-daily safety huddles and structured escalation processes ensure that staffing risks are identified, discussed, and mitigated promptly. • These systems provide live data, allowing managers to reallocate staff, respond to surges in demand, and maintain safe staffing levels. **Impact:** • Real-time staffing data has improved the ability to respond to risks and staffing challenges, leading to safer and more efficient deployment of staff.

- The visibility of staffing gaps and risks has enabled proactive workforce planning, reduced reliance on agency staff, and improved continuity of care.

Workforce Planning Outcome:

- Workforce plans will now incorporate dynamic, real-time data, allowing for more responsive and flexible staffing models.
- The information is used to identify trends, forecast future needs, and inform recruitment and retention strategies.

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2. **Outputs of Staffing Level Tools and Application of the Common Staffing Method (CSM)**

Evidence:

- Annual staffing level tool runs and establishment blueprints for inpatient areas ensure staffing decisions are based on patient needs, local context, and clinical advice.
- The CSM triangulates data from staffing level tools, professional judgement, and quality measures, providing a robust framework for workforce planning.

Impact:

- Outputs from these tools have identified areas where staffing establishments needed to be changed, such as increasing Healthcare Support Worker provision or redesigning services in response to patient feedback and quality data.
- The CSM has supported service reviews and redesigns, ensuring that workforce plans are evidence-based and aligned with the guiding principles of safe, high-quality, and person-centred care.

Workforce Planning Outcome:

- Workforce plans will now be informed by objective, validated tools and frameworks, leading to more accurate establishment setting and resource allocation.
- The process has highlighted the need for targeted recruitment, over-recruitment of newly qualified nurses, and development pathways for healthcare support workers.

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3. **Impact of the Health and Care Staffing Act on Safe and Efficient Staffing**

Evidence:

- Compliance with the Act has led to ongoing improvement in patient safety, quality of care, patient flow, and staff wellbeing.
- Enhanced monitoring and reporting systems, active engagement with staff and service users, robust adverse event reporting, and a culture of continuous improvement and transparency have all contributed to safer staffing.

Impact:

- The Act has driven the rollout of new systems and processes, such as eRostering and Safecare, which have improved the ability to identify and address staffing risks in real time.
- Staff and service user feedback mechanisms have led to service redesigns and targeted improvements, such as new clinics and improved continuity of care.

Workforce Planning Outcome:

- Workforce plans now prioritise safe and efficient staffing, with a focus on continuous improvement, staff wellbeing, and patient-centred care.
- The information from the reports will be used to shape strategic and operational workforce plans, ensuring ongoing compliance with statutory duties and underpinning transparent governance.

Please provide information on how your compliance to the Health and Care Staffing Act has led to improved outcomes for service users and workforce

As set out in the legislation, compliance with the Act should support the outcomes from the Health and Care Standards. Therefore, you should demonstrate/consider how implementation of the Act contributes to achieving these Standards

This should include - but not be limited to - information in relation to patient safety and quality of care measures and outcomes, patient feedback, staff wellbeing measures, and adverse event reporting; what this information has shown and any trends; and any actions taken as a result.

NHS Forth Valley's compliance with the Health and Care Staffing Act has led to measurable improvements in patient safety, quality of care, patient and staff experience, and organisational learning. These improvements are evidenced by enhanced monitoring and reporting systems, active engagement with staff and service users, robust adverse event reporting, and a culture of continuous improvement and transparency.

How Compliance with the Health and Care Staffing Act Has Improved Outcomes;

1. Patient Safety and Quality of Care

- **Real-Time Staffing and Risk Management:**
  The introduction of eRostering and Safecare systems across inpatient and other areas has enabled real-time staffing assessments, supporting safe staffing decisions and rapid response to risks. Twice-daily safety huddles and structured escalation processes ensure that staffing risks are identified, discussed, and mitigated promptly. These systems have led to improved patient safety, reduced incidents of unsafe staffing, and better continuity of care.
- **Quality Improvement Initiatives:**
  Regular analysis of quality standards and safety outcome data has led to targeted quality improvement initiatives. For example, care assurance audits and clinical governance groups in Nursing have improved the robustness of performance monitoring and safe staffing processes. Pharmacy and Laboratory services have achieved or are working towards external accreditations (e.g., ISO 9001:2025, ISO 15189), demonstrating a commitment to quality and continuous improvement.

2. Patient Feedback and Experience

- **Systematic Collection and Use of Feedback:**
  Patient feedback is systematically collected through questionnaires, focus groups, and Care Opinion. For example, in Prison Healthcare, patient forums and questionnaires have been used to gather feedback on care delivery, leading to service improvements. In Maternity, the relaunch of the Maternity Voices Partnership and the introduction of new clinics have led to improved antenatal and postpartum continuity and increased spontaneous vaginal birth rates.
- **Transparency and Communication:**
  Open communication and transparency regarding staffing decisions have fostered trust and collaboration among staff and service users. Actions taken in response to feedback are shared through governance structures, ensuring that service users see tangible changes.

3. Staff Wellbeing Measures

- **Staff Engagement and Wellbeing Initiatives:**
  Regular collection and review of staff feedback through mechanisms such as wellbeing huddles, whistleblowing services, and annual

surveys (e.g., iMatter) have provided valuable insights into staff experience and organisational culture. These insights have informed targeted actions to improve engagement, satisfaction, and performance. Staff wellbeing is prioritised through dedicated support services, wellbeing huddles, and action plans developed from survey results.

- **Protected Learning and Development:**
  Comprehensive training and leadership development programmes, as well as introducing protected learning time, support ongoing staff development and capability building. Staff are given opportunities for professional growth, which has contributed to improved morale and retention.

4. Adverse Event Reporting and Trends

- **Robust Reporting Systems:**
  Adverse events, complaints, and compliments are systematically reported and reviewed at all levels of clinical governance. The use of systems like Safeguard ensures that incidents are captured, analysed, and used for learning. For example, Mental Health and Learning Disabilities services have established adverse event groups and community incident reviews to promote shared learning.
- **Learning from Events:**
  Action plans are developed in response to adverse events and complaints, with learning shared across teams to prevent recurrence and improve care quality. Trends show increased responsiveness to risks, better patient outcomes, and a more resilient and engaged workforce.

What the Information Has Shown and Actions Taken

- **Trends Identified:**
  Increased use of real-time staffing resources has led to earlier identification and mitigation of staffing risks. Patient feedback mechanisms have resulted in service redesigns and targeted improvements, such as new clinics and improved continuity of care. Staff wellbeing initiatives have improved engagement and reduced turnover in key areas. Adverse event reporting has become more robust, with clear escalation and learning processes in place.

- **Actions Taken:**
  Continued rollout of eRostering and Safecare to all areas, using learning from early adopters to support implementation and training. Targeted recruitment campaigns and over-recruitment of newly qualified nurses to address staffing gaps. Development of safety dashboards and balanced scorecards to enhance visibility and communication of staffing actions and feedback. Ongoing review and refinement of escalation and risk recording processes to ensure consistency and effectiveness. Implementation of protected learning time and comprehensive training programmes to support staff development.

Alignment with Health and Care Standards

Compliance with the Health and Care Staffing Act has directly supported the outcomes set out in the Health and Care Standards by:

- Ensuring safe, high-quality, and person-centred care through robust staffing systems and continuous improvement.
- Promoting transparency, engagement, and responsiveness to both staff and service user feedback.
- Embedding a culture of learning from adverse events and sharing best practice across teams.
- Supporting staff wellbeing and professional development as a core component of service delivery.

Health and Care Staffing Act Health Board Duty Compliance Assurance Levels

Please complete the table below with your Health Boards compliance assurance level for each duty.

DUTY	COMPLIANCE ASSURANCE LEVEL
Duty 12IA: Duty To Ensure Appropriate Staffing	Reasonable Assurance
Duty 12IC: Duty To Have Real-Time Staffing Assessment in Place.	Substantial Assurance
Duty 12ID: Duty To Have Risk Escalation Process In Place.	Substantial Assurance
Duty 12IE: Duty To Have Arrangements To Address Severe and Recurrent Risks.	Reasonable Assurance
Duty 12IF: Duty To Seek Clinical Advice on Staffing.	Reasonable Assurance
Duty 12II: Duty To Ensure Appropriate Staffing: Training of Staff	Reasonable Assurance
Duty 12IH: Duty To Ensure Adequate Time Given to Clinical Leaders.	Reasonable Assurance
Duty 12IJ: Duty To Follow the Common Staffing Method (CSM)	Substantial Assurance
Duty 12IL: Training And Consultation of Staff	Reasonable Assurance
Planning And Securing Services	Substantial Assurance
PLEASE INDICATE THE OVERALL LEVEL OF ASSURANCE OF THE ORGANISATION'S COMPLIANCE	
Reasonable Assurance	

Duty 12IA: Duty to ensure appropriate staffing

Duty Description	**2 Guiding principles etc. in health care staffing and planning** (1) In carrying out the duty relating to staffing imposed by section 12IA of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to the guiding principles for health and care staffing. **Duty 12IA: Duty to ensure appropriate staffing.** (**1) It is the duty of every Health Board and the Agency to ensure that at all times suitably qualified and competent individuals, from such a range of professional disciplines as necessary, are working in such numbers as are appropriate** for— (a) the health, wellbeing, and safety of patients, (b) the provision of safe and high-quality health care, and (c) in so far as it affects either of those matters, the wellbeing of staff. (**2) In determining what, in a particular kind of health care provision, constitutes appropriate numbers for the purposes of subsection (1), regard is to be had to—** (a) the nature of the particular kind of health care provision, (b) the local context in which it is being provided, (c) the number of patients being provided it, (d) the needs of patients being provided it, and (e) appropriate clinical advice.
Please provide information on the steps taken to comply with Duty 12IA.	
Please provide information to demonstrate compliance. Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.	

NHS Forth Valley has implemented a range of systems and processes to ensure compliance with Duty 12IA, ensuring that suitably qualified and competent staff from a range of professional disciplines are always available in appropriate numbers to safeguard patient health, wellbeing, and safety, and to support staff wellbeing.

Systems and Processes in Place

NHS Forth Valley has implemented a comprehensive framework to meet these requirements:

- **Workforce Planning and Blueprinting:** Annual staffing level tool runs and establishment blueprints for inpatient areas ensure staffing decisions are based on patient needs, local context, and clinical advice. Service reviews and redesigns are ongoing to adapt to changing requirements across all departments.
- **Real-Time Staffing Assessment:** The introduction of eRostering and Safecare systems enables real-time assessment and allocation of staff, supporting safe and high-quality care. Twice-daily safety huddles and structured escalation processes ensure that staffing risks are identified and mitigated promptly. The use of the OPEL Tool for multisystem assurance is in place.
- **Recruitment and Retention Initiatives:** Targeted recruitment campaigns, over-recruitment of newly qualified nurses, and development pathways for healthcare support workers have been implemented to address staffing gaps and ensure a sustainable workforce.
- **Clinical Advice and Professional Judgement:** Staffing decisions are informed by appropriate clinical advice and professional judgement tools, with escalation processes in place for unresolved risks or disagreements.
- **Staff and Service User Engagement:** Regular collection and review of staff and service user feedback, including annual surveys and focus groups, inform workforce planning and service improvement, ensuring that decisions are person-centred and responsive to local needs.
- **Governance and Assurance:** Clinical governance structures, regular audits, and reporting frameworks ensure oversight and continuous improvement. Risks and non-compliance are identified, escalated, and addressed through established governance routes.

These systems and processes collectively ensure that NHS Forth Valley meets the requirements of Duty 12IA by maintaining appropriate staffing levels, supporting patient safety and quality of care, and promoting staff wellbeing, while remaining responsive to local context and clinical advice. Ongoing monitoring and improvement activities are in place to address any areas of risk or non-compliance.

Please provide Information on your methods of monitoring compliance with Duty 12IA

Compliance with Duty 12IA is monitored through a comprehensive approach that includes annual staffing level tool runs, establishment blueprinting, and the use of real-time staffing systems such as OPEL Tool and Safecare, which provide live data on staffing levels and skill mix. Twice-daily safety huddles and structured escalation processes ensure that staffing risks are identified and addressed promptly. Regular audits, care assurance visits, and clinical governance meetings review compliance and performance, while systematic collection of staff and service user feedback informs ongoing improvement. Incidents and adverse events are reported and analysed using Safecare and Safeguard, with action plans developed in response. Recruitment, retention, and training compliance are also tracked, and risks or non-compliance are escalated through established governance frameworks.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
eRostering and Safecare Implementation (All inpatient areas, progressing to AHP and Medical teams)	The introduction of eRostering and Safecare has enabled real-time assessment and allocation of staff, supporting safer staffing decisions and prompt risk mitigation. Twice-daily safety huddles and structured escalation processes ensure that staffing risks are identified and addressed quickly.	Continue the rollout of eRostering and Safecare to all areas, using learning from early adopters to support implementation and training.
Workforce Planning and Blueprinting	Annual staffing level tool runs and establishment blueprints for inpatient areas ensure staffing decisions are based on patient needs, local context, and clinical advice. Service reviews and redesigns are ongoing to adapt to changing requirements. The medical rota template allows for easy highlighting of gaps, and easy identification of risk that needs mitigated. Where no easy solutions are found immediate escalation up to clinical management structures is immediate either through clinical rota lead or AMD for UUC.	Refine workforce planning processes and monitor the impact of recruitment and retention strategies. Complete blueprint sign-off for all relevant services. Medical teams are collating absence reporting and improvement of structures, as well as a better system to report cross cover or shift alteration requirements.

Recruitment and Retention Initiatives (Nursing, Allied Health Professions, Prison Healthcare)	Targeted recruitment campaigns, over-recruitment of newly qualified nurses, and development pathways for healthcare support workers have addressed staffing gaps and improved workforce resilience.	Continue to evaluate and adapt recruitment and retention initiatives and share best practice across teams.
Clinical Advice and Professional Judgement (All clinical areas)	Staffing decisions are informed by clinical advice and professional judgement tools, with escalation processes in place for unresolved risks or disagreements.	Further embed the use of professional judgement tools and ensure consistent escalation and documentation of staffing risks.
Staff and Service User Engagement (All services)	Regular collection and review of staff and service user feedback (e.g., iMatter surveys, focus groups) inform workforce planning and service improvement, ensuring decisions are person-centred and responsive to local needs.	Further develop feedback mechanisms and ensure learning is systematically used to inform service improvement.
FV has been stepped down from interim reviews by the deanery (Medical).	Despite acute site pressures the medical education teams have successfully provided significant assurance in an ongoing nature to demonstrate improved wellbeing and culture amongst the trainee workforce.	Ongoing work and collaboration with stakeholders,

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
Variability in System Implementation	Inconsistent adoption and robustness of eRostering and Safecare across services; some areas still transitioning.	Continue phased rollout; use learning from early adopters; interim manual processes in place where needed.
Staffing Gaps and Recruitment Challenges	Persistent vacancies and recruitment delays, especially in specialist areas (e.g., midwifery, mental health).	Targeted recruitment campaigns; over-recruitment; workforce reviews and redesigns; regular monitoring. Good staff governance.
Training Compliance and Protected Time	Challenges ensuring all staff complete mandatory training and have protected learning time.	Ongoing monitoring via TURAS/Pentana; action plans for gaps; promote and track protected learning time. OD will oversee this work.
Escalation and Risk Recording	Variability in how risks are escalated and recorded; need for standardisation across services.	Review and update SOPs; provide training; regular review at clinical/staff governance meetings; escalate as required.

Visibility of Safe Staffing Actions	Need to make safe staffing actions more visible to staff, patients and service users; feedback not always consistently shared.	Develop safety dashboards and balanced scorecards; enhance communication of staffing actions and feedback.
Integration of New Tools and Processes	Ongoing transition to new staffing tools/processes (e.g., national midwifery workforce tool); full benefits not yet realised.	Engage with national groups; local testing and feedback; phased implementation plans for successful integration and transition into Safecare.
Medical Staff Rota Monitoring	Rotas across the site for resident grade doctors have been deemed to be non-compliant with residents demonstrating on report that they were unable to take breaks at the requisite times. This is a national issue. Significant financial risk, approximately £2 million for 25/26.	Natural Break Enabling Group established, working with Senior Leadership team and Union representative as well as the resident groups Contract redesign for Resident Doctors is imperative as an ultimate outcome.
Medical Workforce Planning (Drs)	Over reliance on locum staff groups to deliver medical care.	Expansion and integration of non-medical staff to complement medical teams as part of future workforce planning. However, the need for senior decision makers remains. Reduce medical footprint by removing patients from the system that do not require acute site hospital treatment. National issue, ongoing work with DWD workstreams. Realignment of existing budgets to compensate for locum usage, as a recognition of under resourced teams.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12IC: Duty to have real-time staffing assessment in place.

Duty Summary	**(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for the real-time assessment of its compliance with the duty imposed by section 12IA.** **(2) The arrangements under subsection (1) must, in particular, include—** (a) a procedure for the identification, by any member of staff, of any risks caused by staffing levels to—

	(i) the health, wellbeing, and safety of patients, (ii) the provision of safe and high-quality health care, or (iii) in so far as it affects either of those matters, the wellbeing of staff, (b) a procedure for the notification of any such risk to an individual with lead professional responsibility (whether clinical or non-clinical) in the area where the risk was identified, (c) a procedure for the mitigation of any such risks, so far as possible, by such an individual, and a requirement for that individual to seek and have regard to appropriate clinical advice, as necessary, in carrying out such mitigation, (d) raising awareness among staff about the procedures described in paragraphs (a) (b) and (c), (e) encouraging and enabling staff to use the procedures described in paragraphs (a) and (b), (f) training individuals with lead professional responsibility (whether clinical or non-clinical) for particular types of health care in how to implement the arrangements put in place under paragraphs (a) to (e), and (g) ensuring that such individuals receive adequate time and resources to implement those arrangements.

Please provide information on the steps taken to comply with Duty 12IC.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

1. Arrangements for Real-Time Assessment

- **eRostering and Safecare:**
  NHS Forth Valley has implemented eRostering and Safecare systems across nursing teams, with phased roll-out to AHP and medical teams still ongoing. These digital tools provide live analysis of staffing data, enabling real-time identification of risks and compliance with safe staffing requirements.
- **Regular Huddles:**
  Inpatient nursing and other teams conduct twice daily (and once at night) huddles to review staffing levels, risks, and required mitigations. This ensures immediate identification and response to staffing issues. Medical-specific real-time review post-safety huddle, including risks from boarding, locum-run borders teams, and consultant capacity gaps.
- **Manual and Interim Processes:**
  Where eRostering/Safecare is not yet implemented, interim manual processes (e.g., spreadsheets, daily meetings) are in place to ensure real-time assessment continues.

2. Procedures for Identification, Notification, and Mitigation of Risks

a) Identification of Risks

- **Staff Empowerment:**
  Any staff member can identify risks related to staffing levels that may affect patient health, safety, or staff wellbeing.
- **Digital and Manual Reporting:**
  Risks are identified through Safecare, eRostering, incident reporting systems (e.g., Safeguard/IR1), and during daily huddles.

b) Notification of Risks

- **Clear Escalation Pathways:**
  Risks are notified to the individual with lead professional responsibility (clinical or non-clinical) in the relevant area, via Safecare, eRostering, or direct communication during huddles or as they arise throughout the day/night.
- **Standing Operating Procedures (SOPs):**
  SOPs are in place to ensure staff know how and to whom to escalate risks.

c) Mitigation of Risks

- **Immediate Action:**
  The responsible individual is required to mitigate risks as far as possible, seeking and considering appropriate clinical advice as necessary.
- **Escalation Processes:**
  If risks cannot be fully mitigated at the local level, they are escalated to senior management or Board level for further action.

3. Raising Awareness and Enabling Use of Procedures

d) Raising Awareness

- **Training and Communication:**
  Staff are made aware of procedures through induction, ongoing training, and regular communication (e.g., at huddles, team meetings, and via digital platforms).

- **Accessible SOPs:**
  Procedures are documented and accessible to all staff.

e) Encouraging and Enabling Use

- **Supportive Culture:**
  Staff are encouraged and enabled to use risk identification and escalation procedures, with a culture of openness and transparency promoted throughout the organisation.
- **Feedback Mechanisms:**
  Staff feedback is sought and used to improve processes.

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4. Training and Resources for Lead Professionals

f) Training for Lead Professionals

- **Targeted Training:**
  Individuals with lead professional responsibility receive specific training on implementing real-time staffing assessment arrangements, including use of Safecare, eRostering, and risk escalation.
- **Ongoing Development:**
  Training is refreshed regularly and updated as systems evolve.

g) Adequate Time and Resources

- **Protected Time:**
  Lead professionals (e.g., Senior Charge Nurses/Midwives, Team Leaders, Lead ANPs) are allocated protected time within their job plans to fulfil their responsibilities under this duty.
- **Resource Allocation:**
  Adequate resources (IT, administrative support, access to data) are provided to ensure effective implementation.

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5. Examples of Compliance in Practice

- **Inpatient Nursing:**
  Reviewed twice daily and once at night using Safecare; risks discussed and actioned at site huddles. RAG status shared at huddles and emailed to senior teams. SOPs describe escalation processes, including out-of-hours escalation to on-call nurse managers.
- **Prison Healthcare:**
  SOPs and risk escalation plans tailored to service delivery, shared with all staff. Twice daily huddles, use of Safeguard and Pentana for risk recording and escalation. Training on Turas for all staff.
- **Advanced Practice:**
  Lead ANP clinical governance group meets to ensure consistency in reporting and escalation. All Advanced Practice services have processes for reporting, monitoring, and improvement plans. Work continues to finalise mitigation plans and improve feedback logistics.
- **Women & Children, Maternity, Allied Health Professions, Pharmacy, and Others:**
  All have local arrangements for real-time staffing assessment, risk escalation, and mitigation, with ongoing roll-out of digital tools and training.

6. Continuous Improvement and Monitoring

- **Audit and Review:**
  Data from Safecare, eRostering, and incident reporting will be regularly reviewed at governance meetings. Severe and recurring risks will be recorded on risk registers and reviewed for further action.
- **Training Materials:**
  Training materials and sessions are provided for all systems as they are rolled out, ensuring staff are equipped to use them effectively.

In summary:
NHS Forth Valley has robust, multi-layered systems and processes in place to ensure real-time staffing assessment, risk identification and escalation, and mitigation, fully aligned with Duty 12IC. These arrangements are regularly reviewed and improved based on staff feedback, audit findings, and evolving best practice.

Please provide Information on your methods of monitoring compliance with Duty 12IC
This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

NHS Forth Valley uses a combination of digital tools, regular team huddles, incident reporting, governance structures, and ongoing training to monitor compliance with Duty 12IC. Clear escalation pathways and robust audit processes ensure that any areas of non-compliance are addressed promptly and effectively.

1. Digital Systems for Real-Time Monitoring

- **eRostering and Safecare:**
  These digital platforms are the primary tools for real-time monitoring of staffing levels. They provide live data on staffing, highlight gaps, and flag risks. Roll-out is complete for nursing and ongoing for AHP and medical teams.
- **Manual/Interim Processes:**
  Where digital tools are not yet implemented, manual systems (e.g., spreadsheets, daily huddles) are used to ensure real-time assessment continues. Bi-weekly medical rota risk meetings with escalation to AMD/UUC and Medical Director. Oversight of severe/recurrent risks through the Medical Workforce Governance Group and cross-system DWD (Discharge Without Delay) collaborations.

2. Local Arrangements for Ongoing Monitoring

- **Twice Daily Huddles:**
  Inpatient and other clinical teams hold regular huddles (often twice daily) to review staffing, discuss risks, and agree on mitigations. These meetings ensure immediate identification and escalation of issues.
- **Incident Reporting:**
  Staff are encouraged to report staffing-related risks or incidents using systems like Safeguard (IR1). These reports are reviewed for trends and compliance issues.

3. Escalation and Addressing Non-Compliance

- **Clear Escalation Pathways:**
  If a staffing risk is identified, it is escalated to the individual with lead professional responsibility (e.g., Senior Charge Nurse, Team Leader, Lead ANP). If unresolved, it is further escalated to senior management or Board level.
- **Standing Operating Procedures (SOPs):**
  SOPs outline the steps for identifying, escalating, and mitigating risks. These are accessible to all staff and regularly reviewed.

- **Risk Registers:**
  Severe or recurring risks are recorded on risk registers and reviewed at governance meetings for further action.

4. Governance and Audit

- **Governance Groups:**
  Workforce Governance Groups, Programme Boards, and Senior Leadership Teams regularly review compliance data, audit findings, and risk registers.
- **Audit and Review:**
  Data from eRostering, Safecare, and incident reporting is audited to ensure procedures are followed and to identify any areas of non-compliance.

5. Training and Awareness

- **Staff Training:**
  All staff receive training on the use of real-time staffing tools and escalation procedures. Lead professionals receive additional training and have protected time to fulfil their responsibilities.
- **Feedback Mechanisms:**
  Staff are encouraged to provide feedback on processes, and this is used to improve compliance monitoring.

Mechanisms for Escalating and Addressing Non-Compliance

- **Immediate Escalation:**
  Any non-compliance or unresolved risk is escalated through the management structure, up to Board level if necessary.
- **Support and Intervention:**
  Support is provided to teams or individuals struggling with compliance (e.g., additional training, resource allocation, or temporary staffing solutions).
- **Continuous Improvement:**
  Lessons learned from audits, incidents, and feedback are used to update SOPs, training, and digital tools.

Area of success / achievement / learning	Details	Further action
Implementation of eRostering and Safecare	Nursing, AHP, and Pharmacy teams have successfully implemented eRostering and Safecare, enabling live analysis of staffing data and real-time information on staffing levels. This has improved the ability to identify and respond to staffing risks promptly.	Continue phased rollout to all services, provide ongoing training, and use learning from early adopters to support wider implementation.
Twice-Daily Safety Huddles	Inpatient nursing and prison healthcare teams conduct twice-daily safety huddles, allowing staff to discuss staffing positions and clinical demand, ensuring safe staffing and rapid escalation of risks.	Maintain and expand the use of safety huddles and share best practice across other departments.
Structured Escalation Processes	Clear escalation routes and standard operating procedures are in place for managing staffing risks, with processes reviewed and updated regularly. Staff are encouraged to report risks using systems like Safeguard and IR1.	Continue to review and standardise escalation processes, and ensure all staff are trained and confident in their use.
Use of Data Dashboards and Reporting	Development of safety dashboards and balanced scorecards is underway, providing visibility of staffing levels, skill mix, and training requirements for governance and performance monitoring.	Complete rollout of dashboards, ensure data is used for continuous improvement, and communicate findings to staff and service users.
Learning from Adverse Events	Robust adverse event reporting and learning systems ensure incidents are captured, analysed, and used for improvement, with action plans developed and shared across teams.	Continue to strengthen adverse event reporting and embed learning in practice across all services.
Medical Specific	Introduction of a central medical clinical rota lead providing oversight of resident doctor staffing. New escalation structure requiring senior clinical sign-off for additionality. Establishment of the Medical Workforce Oversight Group with strong data-driven governance.	Transition onto Safcecare once eRostering implementation has concluded.

Area of escalation / Challenge / Risk	Details	Further action
Variability in system implementation	Inconsistent adoption and robustness of real-time staffing tools (eRostering, Safecare) across services; some areas still rely on manual processes.	Continue phased rollout of digital tools, provide targeted training and support, maintain interim manual processes where needed.
Standardisation of escalation and risk recording	Variability in how risks are escalated and recorded, leading to inconsistencies in risk management.	Review and update standard operating procedures, deliver training, and use clinical governance meetings for oversight.
Staff training and confidence in new systems	Not all staff are fully trained or confident in using new digital staffing systems.	Ongoing training and support for staff, with regular refreshers and practical guidance.
Data collection and risk management	Inconsistencies in data collection due to partial system implementation.	Interim manual processes in place; full digital integration planned as rollout progresses.
Medical Specific	Software limitations of eRoster for consultant and SAS working patterns. Variability in SafeCare implementation. Persistent consultant shortages leading to recurrent risk escalations.	Work through the issue with eRoster and Safecare. Need to improve notification processes for all staff involved in risk decisions.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12ID: Duty to Have Risk Escalation Process in Place.

Duty Summary	**(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for the escalation of any risk.** (a) identified during the real-time assessment of its staffing levels in accordance with arrangements put in place under section 12IC, and (b)which it has not been possible to mitigate in accordance with the arrangements put in place under that section**.** **(2) The arrangements under subsection (1) of this duty must include:**

a) A procedure for the initial reporting of a risk as described in subsection (1), by an individual with lead professional responsibility (whether clinical or non-clinical) in the area where the risk was identified, to a more senior decision-maker,
b) A requirement for any such decision-maker to seek and have regard to appropriate clinical advice, as necessary, in reaching a decision on the risk, including on how to mitigate it,
c) A procedure for the onward reporting of the risk, as necessary, to a more senior decision-maker in turn, and a requirement for that decision-maker in turn to seek and have regard to appropriate clinical advice, as necessary, in reaching a decision on the risk, including on how to mitigate it,
d) A requirement for the arrangements put in place under paragraph (c) to escalate further in order to reach a final decision on the risk, including in appropriate cases by the reporting of the risk to the members of the Health Board.
e) A procedure for the notification of every decision made following the initial report, and the reasons for it, to:
    (i)any individual who was involved in identifying the risk in accordance with the arrangements put in place under section 12IC(2)(a),
    (ii)any individual who was involved in attempting to mitigate the risk in accordance with the arrangements put in place under section 12IC(2)(c),
    (iii)any individual who was involved in reporting the risk in accordance with the arrangements put in place under paragraph (a), (c) or (d) of this subsection, and
    (iv)any individual who gave clinical advice in accordance with the arrangements put in place under section 12IC(2)(c), or under paragraph (b), (c) or (d) of this subsection,
f) A procedure for those individuals to record any disagreement with any decision made following the initial report,
g) A procedure for those individuals to be able to request a review of the final decision on a risk (other than a final decision made by the members of the Health Board or the Agency) made in accordance with the arrangements put in place under section 12IC(2)(c) or, as the case may be, paragraphs (b), (c) or (d) of this subsection,
h) Raising awareness among staff about the procedures described in paragraphs (a) to (f),
i) Training individuals with lead professional responsibility (whether clinical or non-clinical) for particular types of healthcare, and other senior decision-makers, in how to implement the arrangements put in place under paragraphs (a) to (h), and
j) Ensuring that such individuals receive adequate time and resources to implement those arrangements.

Please provide information on the steps taken to comply with Duty 12ID.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

1. Arrangements for Escalation of Unmitigated Staffing Risks

- **Escalation Pathways:**
  NHS Forth Valley has clear, structured escalation pathways for risks identified during real-time staffing assessment (via eRostering, Safecare, or manual processes) that cannot be mitigated at the local level.
- Medical-specific escalation through rota leads to AMD/UUC and Director of Medical Workforce.

2. Detailed Compliance with Each Requirement

a) Initial Reporting of Risk

- **Process:**
  When a risk is identified and cannot be mitigated locally, the individual with lead professional responsibility (e.g., Senior Charge Nurse, Team Leader, Lead ANP) reports the risk to a more senior decision-maker (e.g., Service Manager, Chief Nurse).
- **Documentation:**
  This is recorded in Safecare, eRostering, or via incident reporting systems (e.g., Safeguard). Red flags can also be raised via Safecare and must be addressed by senior review and escalated as required.

b) Clinical Advice Requirement

- **Process:**
  Senior decision-makers are required to seek and have regard to appropriate clinical advice when deciding how to address the risk. This may involve consulting with clinical leads, on-call managers, or specialist advisors.
- **Evidence:**
  The process is documented in SOPs and reflected in governance meeting minutes.

c) Onward Reporting and Further Escalation

- **Process:**
  If the risk remains unresolved, it is escalated to the next senior level (e.g., Director of Nursing/Midwifery, Executive/Board). Each escalation step requires the decision-maker to seek clinical advice.
- **Governance:**
  Risks may be added to the risk register and reviewed at Workforce Governance Groups or Board meetings.

d) Final Escalation to Board

- **Process:**
  If a risk cannot be resolved at the executive level, it is escalated to the Health Board for a final decision. This ensures the highest level of oversight for unresolved or severe risks.

e) Notification of Decisions

- **Process:**
  All individuals involved in identifying, mitigating, reporting, or advising on the risk are notified of decisions made at each stage, including the rationale.
- **Mechanism:**
  Notifications are provided via Safecare, email, or meeting minutes.

f) Recording Disagreement

- **Process:**
  Individuals can record disagreement with any decision made following the initial report.
- **Mechanism:**
  Safecare and incident reporting systems allow for the documentation of dissent or alternative views.

g) Requesting Review of Decisions

- **Process:**
  Individuals may request a review of the final decision (unless made by the Board). Feedback and appeal process in place.
- **Mechanism:**
  Requests are submitted through established governance channels.

h) Raising Awareness

- **Process:**
  Staff are made aware of escalation procedures through induction, ongoing training, SOPs, and regular communication (e.g., huddles, team meetings).

i) Training for Leads and Decision-Makers

- **Process:**
  Individuals with lead professional responsibility and senior decision-makers receive training on escalation procedures, use of Safecare/eRostering, and risk management.
- **Ongoing Development:**
  Training is refreshed regularly and updated as systems evolve.

j) Time and Resources

- **Process:**
  Lead professionals and decision-makers are allocated protected time and resources (IT, admin support) to fulfil their escalation responsibilities.

Examples of Local Arrangements and Escalation in Practice

- **Inpatient Nursing:**
  Twice daily huddles review staffing risks. Unresolved risks are escalated from the ward to site management, then to the executive team, and if necessary, to the Board. All steps are documented and communicated.
- **Prison Healthcare:**
  SOPs and risk escalation plans are tailored to the service. Risks are discussed at daily huddles, escalated to senior managers, and recorded in Safeguard/Pentana. All staff are trained on these processes.
- **Advanced Practice:**
  Lead ANP governance meetings ensure consistency in escalation. Risks are escalated through clinical and operational lines, with documentation and feedback at each stage.

In summary:
NHS Forth Valley has robust, multi-layered systems and processes in place to ensure effective risk escalation for staffing issues, fully aligned with Duty 12ID. These arrangements are regularly reviewed and improved based on staff feedback, audit findings, and evolving best practice.

Please provide Information on your methods of monitoring compliance with Duty 12ID

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

1. Digital and Manual Monitoring Systems

- **eRostering and Safecare:**
  These systems are used to record, track, and escalate staffing risks in real time. They provide an auditable trail of risk identification, escalation steps, and outcomes.
- **Incident Reporting (Safeguard/IR1):**
  All staffing-related risks and escalation actions can be logged in the incident reporting system, which is regularly reviewed for trends and compliance.

2. Local Arrangements for Ongoing Monitoring

- **Twice Daily Huddles:**
  Clinical teams hold regular huddles to review staffing risks, discuss escalation actions, and ensure all issues are being addressed according to protocol.
- **Standing Operating Procedures (SOPs):**
  SOPs outline the escalation process, including who is responsible at each stage and how to document actions taken.

3. Escalation and Addressing Non-Compliance

- **Clear Escalation Pathways:**
  If a risk cannot be mitigated locally, it is escalated to the next senior decision-maker, with further escalation up to Board level if necessary. Each step is documented in Safecare or the incident reporting system.

- **Risk Registers:**
  Severe or recurring risks are added to risk registers and reviewed at governance meetings.
- **Notification and Feedback:**
  All individuals involved in the risk process are notified of decisions and can record disagreement or request a review, ensuring transparency and accountability.

4. Governance and Audit

- **Workforce Governance Groups & Programme Boards:**
  These groups regularly review escalation data, audit compliance with escalation procedures, and ensure that unresolved risks are addressed.
- **Audit and Review:**
  Regular audits of Safecare, eRostering, and incident reporting data are conducted to ensure that escalation procedures are being followed and to identify any areas of non-compliance.

5. Training and Awareness

- **Staff Training:**
  All staff, especially those with lead professional responsibility, receive training on escalation procedures and the use of digital tools.
- **Ongoing Communication:**
  Procedures are reinforced through induction, ongoing training, and regular communication at team meetings and huddles.

Mechanisms for Escalating and Addressing Non-Compliance

- **Immediate Escalation:**
  Any non-compliance or unresolved risk is escalated through the management structure, up to Board level if necessary.
- **Support and Intervention:**
  Additional training, resource allocation, or process review is provided to teams or individuals struggling with compliance.
- **Continuous Improvement:**
  Lessons learned from audits, incidents, and feedback are used to update SOPs, training, and escalation pathways.

In summary:
NHS Forth Valley uses a combination of digital tools, regular team huddles, incident reporting, governance structures, and ongoing training to monitor compliance with Duty 12ID. Clear escalation pathways and robust audit processes ensure that any areas of non-compliance are addressed promptly and effectively.

Area of success / achievement / learning	Details	Further action
Clear Escalation Pathways in Nursing (Falkirk, Clacks & Stirling HSCP, Acute Services)	Senior decision-makers and escalation chains have been clearly identified and communicated to all staff. Staff are now much more aware of who to contact during any shift if a risk needs to be escalated. Twice daily and nightly reviews using SafeCare, with RAGG status shared at huddles and by email, ensure risks are visible and acted upon.	The procedures for identifying and communicating escalation chains are being embedded in other clinical areas and will be standardised as eRoster and SafeCare are rolled out further.
Tailored SOPs and Risk Escalation in Prison Healthcare	SOPs and risk escalation plans have been developed and tailored to the specific needs of prison healthcare. These have been shared with all staff, ensuring everyone understands their role in risk assessment and escalation. Staff demonstrate awareness and compliance in daily discussions and huddles.	The approach to developing tailored SOPs is being used as a model for other specialist services. Ongoing review and adaptation will ensure continued relevance and effectiveness.
Red Flag System and Staff Voice (Acute Services)	The introduction of the red flag system in SafeCare allows staff to raise concerns, record disagreements, and escalate wellbeing issues. This has improved transparency and responsiveness to staffing risks.	The red flag system is being rolled out to additional areas as SafeCare implementation expands. Data from red flags will be used to identify trends and inform workforce planning.
Interim Escalation Tools in Psychology	While transitioning to e-rostering, Psychology services have used interim spreadsheets and existing supervision structures to ensure risks are escalated and reviewed. Disagreements are recorded via minutes in governance forums, ensuring transparency.	Lessons from the interim approach are informing the transition to digital tools and will help standardise escalation and review processes across all services.

Real-Time Staffing and Escalation Cards in Maternity	Real-time staffing assessments and escalation cards are used to inform huddles and ensure timely escalation. Professional on-call arrangements provide clinical advice out of hours.	The escalation card approach is being refined based on staff feedback and will be updated and shared across other directorates.

Area of escalation / Challenge / Risk	Details	Further action
Variation in Escalation Process Robustness (Nursing, Acute Services, Medicine and HSCPs)	There is variability in how robustly escalation processes are applied across different wards/units and services. Some areas have well-established SOPs and use Safecare/eRoster, while others are still developing or embedding these processes.	Ongoing rollout of Safecare and eRoster to all areas. Continued training and standardisation of escalation SOPs. Development of safety dashboards and balanced scorecards to monitor compliance and highlight gaps.
Incomplete Mitigation Plans (Acute Services, Advanced Practice)	Some specialties and advanced practice teams have not yet finalised mitigation plans for reporting red status (unmitigated risks). Reporting is sometimes done via Microsoft Forms, which is not always completed robustly.	Teams are working to finalise and embed mitigation plans. There is a focus on improving the logistics of daily staffing mitigations and ensuring consistent recording of disagreements and actions.
Challenges with SafeCare Implementation (Maternity, Advanced Practice, AHP, HCS)	Safecare and eRoster are not yet fully implemented in all areas, particularly in maternity, advanced practice, AHP, and Healthcare Science. This limits real-time visibility and standardisation of risk escalation.	Continued phased rollout of Safecare and eRoster, with interim processes (e.g., spreadsheets, manual reporting) in place. Training and support are being provided to teams as systems are introduced.
Difficulty in Notifying All Relevant Individuals (All Areas)	Ensuring that all individuals involved in reporting, mitigating, escalating, or giving clinical advice are notified of decisions and reasons can be challenging, especially in areas without full digital systems.	Emphasis on using Safecare, eRoster, and governance forums for documentation and communication. Staff are encouraged to use red flag systems and incident reporting to ensure concerns are captured and escalated.
Variation in Recording Disagreement (Acute Services, Advanced Practice)	There is variation across sites and disciplines in how disagreements with decisions are recorded and managed. Some areas use Safecare, others rely on governance forums or manual records.	Standardisation of disagreement recording processes is underway, with training and guidance being provided. Safecare's red flag system is being promoted as the preferred method.
Limited Engagement in Some Services (HCS, Advanced Practice)	Not all Healthcare Science services are fully engaged with the HCSSA implementation. Advanced Practice teams face challenges due to the multi-professional	Ongoing engagement and support to bring all services into scope. Interim plans and tailored SOPs are being developed. National work is

	nature of their work and lack of a dedicated workforce tool.	ongoing to develop appropriate tools for advanced practice.
Visibility of Safe Staffing Actions to Patients (Women & Children, Maternity)	Improvements are needed to make safe staffing actions more visible to patients and service users.	Plans are in place to enhance communication and visibility, with board-wide and national support being sought. Progress will be reviewed in the next reporting period.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12IE: Duty to have arrangements to address severe and recurrent risks.

Duty Summary	**Duty to have arrangements to address severe and recurrent risks.** **(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements to—** (a) collate information relating to every risk escalated to such level as the Health Board or the Agency (as the case may be) consider appropriate in accordance with the arrangements put in place under section 12ID (2), and (b) identify and address those risks which are considered to be either or both— (i) severe, (ii) liable to materialise frequently. **(2) The arrangements under subsection (1) must, in particular, include a procedure for—** (a) the recording of a risk as described in subsection (1)(b), (b) the reporting of any such risk, as necessary, to a more senior decision-maker, including in appropriate cases to the members of the Health Board or the Agency (as the case may be), (c) the mitigation of the risk, so far as possible, and a requirement for appropriate clinical advice to be sought and had regard to in carrying out such mitigation, and (d) the identification of actions to prevent the future materialisation of the risk, so far as possible.

Please provide information on the steps taken to comply with Duty 12IE.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

1. Collation and Identification of Severe and Recurrent Risks

- **Digital Tools for Risk Collation:**
  NHS Forth Valley uses Safecare and eRoster systems across nursing teams (with rollout to AHP and Medical teams ongoing) to enable live analysis of staffing data. These systems help identify and collate information on risks escalated to appropriate levels.
  - Risks are categorised using a RAGG (Red-Amber-Green-Gray) status, which is shared at site safety huddles and emailed to senior teams.
  - Areas remaining in red and unable to mitigate are highlighted for further review and escalation.
  - Staff are encouraged to report risks using the Safeguard system (IR1). Data from this system is used to identify severe and recurring risks, which are then recorded on the appropriate risk register and reviewed regularly.

- Implements actions to prevent recurrence (e.g., redesign of medical footprint, Natural Break Enabling Group).

2. Recording and Escalation Procedures

- **Recording Risks:**
  All severe and recurrent risks are recorded in Safecare, eRoster, or the Safeguard system and can be analysed regularly to see patterns or recurrence or themes. For areas not yet on digital systems, interim processes (e.g., spreadsheets, manual reporting) are used.
- **Escalation Pathways:**
  Risks are escalated from the initial reporter to more senior decision-makers, including, where appropriate, to Health Board members. There are clear SOPs for escalation, including out-of-hours processes.
- **Governance Review:**
  Reports are pulled from systems for review by lead nurses or managers, who escalate shifts as necessary and advise on mitigation. Clinical governance groups and performance structures provide oversight and allow for escalation of issues.

3. Mitigation and Clinical Advice

- **Mitigation Actions:**
  Teams are required to take action to mitigate risks as far as possible. Where risks cannot be fully mitigated, structured escalation routes are followed to ensure no risk is left unchecked.
- **Seeking Clinical Advice:**
  Appropriate clinical advice is sought and considered at each stage of mitigation. This is documented in Safecare, governance forums, or other records.

4. Preventing Future Risks

- **Analysis and Learning:**
  Data from real-time staffing tools, incident reports, and governance reviews are analysed to identify trends and root causes of severe and recurrent risks. Actions are identified and implemented to prevent future materialisation of similar risks.

- **Continuous Improvement:**
  Regular review and revision of risk management systems and processes are undertaken to enhance effectiveness. Training materials and sessions are provided as systems are rolled out.

In summary:
NHS Forth Valley has robust arrangements in place to identify, record, escalate, and address severe and recurrent staffing risks, with clear procedures for mitigation, clinical advice, and prevention of future risks. These arrangements are supported by digital tools, governance structures, and ongoing training and review, ensuring compliance with Duty 12IE.

Please provide Information on your methods of monitoring compliance with Duty 12IE

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

1. Digital Tools and Real-Time Monitoring

- **Safecare and eRoster:**
  NHS Forth Valley uses Safecare and eRoster to enable live analysis of staffing data. These systems help identify, record, and collate information on risks escalated to appropriate levels.
  - Risks are categorised using a RAGG (Red-Amber-Green-Gray) status, which is shared at site safety huddles and emailed to senior teams.
  - Areas remaining in red and unable to mitigate are highlighted for further review and escalation.
  - For areas not yet on digital systems, interim processes (e.g., spreadsheets, manual reporting) are used to ensure risks are still captured and escalated.
- **Safeguard System (IR1):**
  Staff are encouraged to report risks using the Safeguard system (IR1). Data from this system is used to identify severe and recurring risks, which are then recorded on the appropriate risk register and reviewed regularly at governance meetings.

2. Recording, Escalation, and Governance Review

- **Recording Risks:**
  All severe and recurrent risks are recorded in Safecare, eRoster, or Safeguard. For areas not yet on digital systems, interim manual processes are used.
- **Escalation Pathways:**
  Risks are escalated from the initial reporter to more senior decision-makers, including, where appropriate, to Health Board members. There are clear SOPs for escalation, including out-of-hours processes.
- **Governance Review:**
  Reports are pulled from systems for review by lead nurses or managers, who escalate shifts as necessary and advise on mitigation. Clinical governance groups and performance structures provide oversight and allow for escalation of issues. Severe and recurring risks are added to the risk register and reviewed at governance meetings.

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3. Addressing Non-Compliance and Continuous Improvement

- **Mechanisms for Addressing Non-Compliance:**
  - If a risk is not addressed or if there is a failure to follow escalation procedures, this is identified through regular governance reviews and audits.
  - Any severe or recurring risks are escalated to the appropriate risk register and reviewed at governance meetings.
  - There are clear mechanisms for escalating risks and addressing non-compliance, with a focus on learning and prevention.
  - Feedback from staff and governance forums is used to identify gaps and drive improvements.
- **Continuous Improvement:**
  - Data from real-time staffing tools, incident reports, and governance reviews are analysed to identify trends and root causes of severe and recurrent risks.
  - Actions are identified and implemented to prevent future materialisation of similar risks.
  - Regular review and revision of risk management systems and processes are undertaken to enhance effectiveness.
  - Training materials and sessions are provided as systems are rolled out.

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4. Service-Specific Monitoring

- **Prison Healthcare:**
  SOPs and risk escalation plans are tailored to service needs, with twice-daily staffing huddles and clinical governance approval. Risks are recorded and monitored using IR1 and Pentana systems.
- **Acute Services:**
  The red flag system in Safecare enables staff to raise concerns, record disagreements, and escalate wellbeing issues. Trends can be analysed by shift, day, and flag owner.
- **Psychology:**
  Interim spreadsheets support escalation while transitioning to e-rostering; risks are escalated and reviewed in operational and clinical supervision structures. Severe and recurring risks are reported at governance groups and senior leadership huddles.
- **Women & Children, Maternity, AHP, HCS:**
  Similar arrangements are in place, with escalation processes, risk registers, and regular review through governance structures.

5. Training and Staff Awareness

- **Ongoing Training:**
  Training materials and sessions are provided for all systems as they are rolled out (e.g., Safecare, eRoster, Turas). Ongoing training and refresher sessions are planned, with feedback from staff shaping content. SOPs and risk escalation plans are widely shared with all healthcare teams to ensure awareness of duties and escalation steps.

In summary:
NHS Forth Valley monitors compliance with Duty 12IE through a combination of real-time digital tools, robust SOPs, regular governance reviews, and continuous training and improvement. There are clear mechanisms for escalating and addressing non-compliance, ensuring that severe and recurrent risks are identified, escalated, and addressed promptly, with learning and prevention at the core of the process.

Area of Success / Achievement / Learning	Details	Further Action
Implementation of SafeCare and eRoster in Nursing, AHP, Medicine and Pharmacy	The rollout of SafeCare and eRoster has enabled live analysis of staffing data, allowing for real-time identification and escalation of severe and recurrent risks. This has improved the ability to respond promptly to staffing	Continue phased rollout to all services, provide ongoing training, and use learning from early adopters to support wider implementation.

Area of Success / Achievement / Learning	Details	Further Action
	challenges and has standardised risk recording and escalation processes across multiple teams.	
Twice-Daily Safety Huddles (Inpatient Nursing & Prison Healthcare)	Regular safety huddles have created a structured forum for staff to discuss and escalate risks, ensuring that issues are identified early and addressed collaboratively. This approach has improved communication and responsiveness to emerging risks.	Maintain and expand the use of safety huddles, share best practice across other departments, and use feedback to refine the process.
Red Flag System in SafeCare (Acute Services)	The introduction of the red flag system allows staff to raise concerns and record disagreements about staffing decisions, increasing transparency and enabling trends in severe or recurrent risks to be analysed over time.	Expand the red flag system to additional areas, use data to inform workforce planning, and ensure staff are trained and confident in its use.
Tailored SOPs and Risk Escalation in Prison Healthcare	SOPs and risk escalation plans have been developed to meet the specific needs of prison healthcare, ensuring all staff understand their role in risk assessment and escalation. Staff demonstrate awareness and compliance in daily discussions and huddles.	Use the approach to developing tailored SOPs as a model for other specialist services, with ongoing review and adaptation for continued relevance.
Interim Escalation Tools in Psychology	While transitioning to e-rostering, Psychology services have used interim spreadsheets and existing supervision structures to ensure risks are escalated and reviewed. Disagreements are recorded in the minutes of governance forums, ensuring transparency.	Lessons from the interim approach are informing the transition to digital tools and will help standardise escalation and review processes across all services.
Learning from Adverse Events	Robust adverse event reporting and learning systems ensure incidents are captured, analysed, and used for improvement, with action plans developed and shared across teams.	Continue to strengthen adverse event reporting and embed learning in practice across all services.
Development of Safety Dashboards and Balanced Scorecards	Work is underway to develop dashboards that provide visibility of staffing levels, skill mix, and training requirements, supporting governance and performance monitoring.	Complete rollout of dashboards, ensure data is used for continuous improvement, and communicate findings to staff and service users.

Area of Escalation / Challenge / Risk	Details	Further Action
Variation in Escalation Process Robustness (Nursing, Acute Services, Medicine and HSCPs)	There is variability in how robustly escalation processes are applied across different wards/units and services. Some areas have well-established SOPs and use Safecare/eRoster, while others are still developing or embedding these processes.	Ongoing rollout of Safecare and eRoster to all areas. Continued training and standardisation of escalation SOPs. Development of safety dashboards and balanced scorecards to monitor compliance and highlight gaps.
Incomplete Mitigation Plans (Acute Services, Advanced Practice)	Some specialties and advanced practice teams have not yet finalised mitigation plans for reporting red status (unmitigated risks). Reporting is sometimes done via Microsoft Forms, which is not always completed robustly.	Teams are working to finalise and embed mitigation plans. There is a focus on improving the logistics of daily staffing mitigations and ensuring consistent recording of disagreements and actions.
Challenges with SafeCare Implementation (Maternity, Advanced Practice, AHP, HCS)	Safecare and eRoster are not yet fully implemented in all areas, particularly in maternity, advanced practice, AHP, and Healthcare Science. This limits real-time visibility and standardisation of risk escalation.	Continued phased rollout of SafeCare and eRoster, with interim processes (e.g., spreadsheets, manual reporting) in place. Training and support are being provided to teams as systems are introduced.
Difficulty in Notifying All Relevant Individuals (All Areas)	Ensuring that all individuals involved in reporting, mitigating, escalating, or giving clinical advice are notified of decisions and reasons can be challenging, especially in areas without full digital systems.	Emphasis on using SafeCare, eRoster, and governance forums for documentation and communication. Staff are encouraged to use red flag systems and incident reporting to ensure concerns are captured and escalated.
Variation in Recording Disagreement (Acute Services, Advanced Practice)	There is variation across sites and disciplines in how disagreements with decisions are recorded and managed. Some areas use SafeCare, others rely on governance forums or manual records.	Standardisation of disagreement recording processes is underway, with training and guidance being provided. SafeCare's red flag system is being promoted as the preferred method.
Limited Engagement in Some Services (HCS, Advanced Practice)	Not all Healthcare Science services are fully engaged with the HCSSA implementation. Advanced Practice teams face challenges due to the multi-professional nature of their work and lack of a dedicated workforce tool.	Ongoing engagement and support to bring all services into scope. Interim plans and tailored SOPs are being developed. National work is ongoing to develop appropriate tools for advanced practice.

Area of Escalation / Challenge / Risk	Details	Further Action
Visibility of Safe Staffing Actions to Patients (Women & Children, Maternity)	Improvements are needed to make safe staffing actions more visible to patients and service users.	Plans are in place to enhance communication and visibility, with board-wide and national support being sought. Progress will be reviewed in the next reporting period.

Duty 12IF: Duty to Seek Clinical Advice on Staffing.

Duty Summary	**Duty to Seek Clinical Advice on Staffing.** **(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for—** (a) seeking and having regard to appropriate clinical advice in making decisions and putting in place arrangements in relation to staffing under sections 12IA to 12IE and 12IH to 12IL, (b) recording and explaining decisions which conflict with that advice. **(2) The arrangements under subsection (1) must, in particular, include—** (a) where a Health Board or the Agency (as the case may be) reaches a decision on a matter which conflicts with the clinical advice it has received— (i) a procedure for the identification of any risks caused by that decision, (ii) a procedure for the mitigation of any such risks, so far as possible, (iii) a procedure for the notification of any such decision, and the reasons for it, to any individual who gave clinical advice on the matter, (iv) a procedure for any such individual to record any disagreement with the decision made on the matter, (b)a procedure for individuals with lead clinical professional responsibility for a particular type of health care to report to the members of the Health Board or the Agency (as the case may be), on at least a quarterly basis, about the extent to which that individual considers that it is complying with the duties imposed by— (i) this section, and (ii) sections 12IA to 12IE and 12IH to 12IL, (c) a procedure for such individuals to— (i) enable and encourage other employees to give views on the operation of this section, and (ii) record such views in reports made in accordance with the arrangements put in place under paragraph (b), (d) raising awareness among individuals with lead clinical professional responsibility for particular types of health care in how to implement the arrangements put in place under paragraphs (a) to (c), and (e) ensuring that such individuals receive adequate time and resources to implement those arrangements. **(3) Every Health Board and the Agency must have regard to the reports received in accordance with the arrangements put in place under subsection (2)(b).**

Please provide information on the steps taken to comply with Duty 12IF.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

1. Seeking and Having Regard to Clinical Advice

- **Structured Processes:**
  NHS Forth Valley has established clear procedures to ensure that appropriate clinical advice is sought and considered in all staffing decisions and arrangements covered by sections 12IA to 12IE and 12IH to 12IL.
  - Clinical advice is routinely sought during workforce planning, risk escalation, and mitigation processes.
  - Escalation pathways (e.g., from Senior Charge Nurse to Chief Nurse/Service Manager) ensure clinical input at every stage.
  - Professional judgement tools (in scope) and multidisciplinary team discussions are used to inform decisions.
  - Medical rota and staffing decisions involve consultant clinical leads and AMD/UUC

2. Recording and Explaining Decisions that Conflict with Clinical Advice

- **Documentation:**
  - Where a decision is made that conflicts with clinical advice, the rationale will be recorded in SafeCare, eRoster, or governance forums.
  - The red flag system in SafeCare allows staff to record disagreements and escalate concerns.
  - All such decisions, including the reasons for diverging from clinical advice will be documented and communicated to those who provided the advice.

3. Procedures for Risk Identification, Mitigation, and Notification

- **Risk Identification and Mitigation:**
  - If a decision conflicts with clinical advice, risks are identified and assessed using structured tools and SOPs.
  - Mitigation actions are taken as far as possible, with further clinical advice sought if needed.
  - All individuals involved in giving clinical advice are notified of the decision and the reasons for it.
  - There is a clear process for those individuals to record any disagreement with the decision.

4. Quarterly Reporting to the Health Board

- **Lead Clinical Professional Reporting:**
  - Individuals with lead clinical responsibility (e.g., Chief Nurses, Heads of Service) report at to the Health Board on compliance with staffing duties, including Duty 12IF.
  - These reports include details of compliance, areas of challenge, and any instances where decisions have conflicted with clinical advice.

5. Enabling and Recording Staff Views

- **Staff Engagement:**
  - Staff are encouraged to provide views on staffing arrangements and the operation of Duty 12IF through surveys (e.g., iMatter), focus groups, and team meetings.
  - These views are recorded and included in quarterly reports.
  - Mechanisms such as the red flag system and regular feedback forums ensure staff can raise concerns and have them formally considered.

6. Raising Awareness and Training

- **Awareness and Training:**
  - SOPs and escalation plans are widely shared, and staff are trained on how to seek, provide, and record clinical advice.
  - Ongoing training and refresher sessions are provided as systems are rolled out.
  - Lead clinical professionals receive dedicated time and resources to fulfil their responsibilities, including training and protected time for governance activities.

7. Ensuring Adequate Time and Resources

- **Resource Allocation:**
  - eRoster and SafeCare can provide reports for governance review, supporting oversight and resource planning.

- Protected time is allocated for clinical leaders to supervise, manage, and lead on staffing matters.

In summary:
NHS Forth Valley has robust systems and processes to ensure clinical advice is sought, considered, and documented in all staffing decisions. There are clear mechanisms for recording and explaining decisions that conflict with clinical advice, identifying and mitigating associated risks, and ensuring staff at all levels can contribute their views. Regular reporting, ongoing training, and resource allocation underpin compliance with Duty 12IF.

Please provide Information on your methods of monitoring compliance with Duty 12IF

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance

1. Digital Systems and Documentation

- **SafeCare and eRoster:**
  NHS Forth Valley uses SafeCare and eRoster to document clinical advice, record decisions (including those that conflict with advice), and track risk mitigation actions.
  - The red flag system in SafeCare allows staff to record disagreements and escalate concerns about staffing decisions.
  - All such decisions, including the rationale for diverging from clinical advice, are documented and communicated to those who provided the advice.

2. Escalation and Governance Pathways

- **Escalation Procedures:**
  - If a decision conflicts with clinical advice, risks are identified and assessed using structured tools and SOPs.
  - Mitigation actions are taken as far as possible, with further clinical advice sought if needed.
  - All individuals involved in giving clinical advice are notified of the decision and the reasons for it.
  - There is a clear process for those individuals to record any disagreement with the decision.
- **Governance Oversight:**
  - Clinical governance groups and performance structures provide oversight, allowing for escalation of issues and regular review of compliance.

- Reports from SafeCare and eRoster are used for service and clinical governance review.
- Any severe or recurring risks are escalated to the appropriate risk register and reviewed at governance meetings.

3. Quarterly Reporting and Staff Engagement

- **Quarterly Reports:**
  - Individuals with lead clinical responsibility (e.g., Chief Nurses, Heads of Service) report to the Health Board on compliance with staffing duties, including Duty 12IF.
  - These reports include details of compliance, areas of challenge, and any instances where decisions have conflicted with clinical advice.
- **Staff Engagement and Feedback:**
  - Staff are encouraged to provide views on staffing arrangements and the operation of Duty 12IF through surveys (e.g., iMatter), focus groups, and team meetings.
  - These views are recorded and included in quarterly reports to the Board.
  - Mechanisms such as the red flag system and regular feedback forums ensure staff can raise concerns and have them formally considered.

4. Addressing Non-Compliance

- **Mechanisms for Addressing Non-Compliance:**
  - If a risk is not addressed or if there is a failure to follow escalation procedures, this is identified through regular governance reviews and audits.
  - Any severe or recurring risks are escalated to the appropriate risk register and reviewed at governance meetings.
  - There are clear mechanisms for escalating risks and addressing non-compliance, with a focus on learning and prevention.
  - Feedback from staff and governance forums is used to identify gaps and drive improvements.

5. Training and Awareness

- **Ongoing Training:**
  - Training materials and sessions are provided for all systems as they are rolled out (e.g., SafeCare, eRoster, Turas).
  - Ongoing training and refresher sessions are planned, with feedback from staff shaping content.
  - SOPs and escalation plans are widely shared with all healthcare teams to ensure awareness of duties and escalation steps.

In summary:
NHS Forth Valley monitors compliance with Duty 12IF through a combination of digital documentation, robust SOPs, regular governance reviews, quarterly reporting, staff engagement, and continuous training. There are clear mechanisms for escalating and addressing non-compliance, ensuring that clinical advice is sought, considered, and acted upon in all staffing decisions.

Area of Success / Achievement / Learning	Details	Further Action
Staff Engagement in Clinical Advice (Nursing, Acute Services)	Staff feedback collected via iMatter surveys and team meetings identified that involving frontline nurses in staffing decisions improved morale and the appropriateness of staffing allocations.	This approach is being formalised and extended to other wards, with regular feedback loops and inclusion of staff views in quarterly reports to the Board.
Red Flag System for Disagreement (Acute Services, Women & Children)	The introduction of the red flag system in SafeCare allows staff to formally record disagreements with staffing decisions that conflict with clinical advice. This has increased transparency and enabled trends to be analysed.	The system is being rolled out to additional areas, and data from red flags will be used to inform future workforce planning and training.
Quarterly Reporting and Learning (Allied Health Professions, Psychology)	Quarterly reports from lead clinical professionals have highlighted areas where clinical advice was not followed and the reasons why. This has led to targeted reviews and improvements in escalation processes.	The learning from these reviews is being shared across other professional groups, and the reporting template is being refined to better capture staff views and disagreements.
Multidisciplinary Team (MDT) Involvement (Maternity, Prison Healthcare)	MDT meetings have enabled a broader range of clinical advice to be considered in staffing decisions, leading to more robust risk assessments and mitigation plans.	The MDT approach is being embedded as standard practice, with plans to evaluate its impact on patient outcomes and staff satisfaction.
Training and Awareness (All Services)	Training sessions and SOPs have increased awareness among clinical leaders about their responsibilities to seek, record, and act on clinical advice. Staff now report greater confidence in raising concerns and understanding escalation pathways.	Ongoing refresher training and updates to SOPs are planned, with feedback from staff used to continuously improve the process.

Area of Escalation / Challenge / Risk	Details	Further Action
Variation in Mechanisms for Seeking Staff Views (Medical, Allied Health Professions)	In compiling reports to the Health Board, mechanisms for seeking the views of some professional groups (e.g., medicine, AHPs) are not as well established as those for nursing and midwifery staff. As a result, the views of these employees may not be consistently sought or incorporated into reports.	Work is underway to develop and standardise feedback mechanisms for all professional groups, including regular surveys, focus groups, and inclusion of staff representatives in governance meetings. Training and communication are being enhanced to ensure all groups are engaged.
Recording and Acting on Disagreement (Acute Services, Advanced Practice)	There is variation across sites and disciplines in how disagreements with decisions (especially those that conflict with clinical advice) are recorded and managed. Some areas use SafeCare's red flag system, others rely on governance forums or manual records.	Standardisation of disagreement recording processes is underway, with training and guidance being provided. SafeCare's red flag system is being promoted as the preferred method.
Limited Engagement in Some Services (Healthcare Science, Advanced Practice)	Not all Healthcare Science services are fully engaged with the process of seeking and recording clinical advice. Advanced Practice teams face challenges due to the multi-professional nature of their work and lack of a dedicated workforce tool.	Ongoing engagement and support to bring all services into scope. Interim plans and tailored SOPs are being developed. National work is ongoing to develop appropriate tools for advanced practice.
Difficulty in Notifying All Relevant Individuals (All Areas)	Ensuring that all individuals involved in giving clinical advice are notified of decisions and reasons can be challenging, especially in areas without full digital systems.	Emphasis on using SafeCare, eRoster, and governance forums for documentation and communication. Staff are encouraged to use red flag systems and incident reporting to ensure concerns are captured and escalated.
Protected Time and Resources for Clinical Leaders (All Services)	Ensuring that clinical leaders have adequate time and resources to fulfil their responsibilities, including seeking and recording clinical advice, remains a challenge in some areas.	Protected time is being reviewed and allocated through eRoster and job planning. Ongoing monitoring and feedback are used to adjust resource allocation as needed.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12IH: Duty to ensure adequate time given to clinical leaders.

Duty Summary	**In complying with the duty imposed by section 12IA, every Health Board and the Agency must ensure that all individuals with lead clinical professional responsibility for a team of staff receive sufficient time and resources to discharge that responsibility and their other professional duties, including, in particular, time—** (a) to supervise the meeting of the clinical needs of the patients in their care, (b) to manage, and support the development of, the staff for whom they are responsible, and (c) to lead the delivery of safe, high-quality, and person-centred health care.

Please provide information on the steps taken to comply with Duty 12IH.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

1. Ensuring Sufficient Time and Resources for Clinical Leaders

- **Job Planning and Protected Time:**
  NHS Forth Valley uses job planning and eRoster systems to allocate and monitor protected time for individuals with lead clinical professional responsibility (e.g., Senior Charge Nurses, Team Leaders, Heads of Service).
  - For example, Senior Charge Nurses (SCNs) are allocated 40% non-clinical time to focus on managerial aspects of their role and 60% clinical time. This split is reflected within eRosters and reviewed regularly.
  - Nursing leads in areas such as immunisation, health visiting, and school nursing are non-caseload holding, ensuring they have protected time to supervise, support, and lead their teams.
- **Leadership and Supervision:**
  Clinical leaders are given time to supervise the meeting of clinical needs, manage and support staff development, and lead the delivery of safe, high-quality, person-centred care.
  - Monthly leadership days and regular attendance at clinical governance, review groups, and professional meetings are standard practice in directorates such as Maternity and Women & Children.
  - Clinical leaders participate in working groups to determine what sufficient time and resources look like for their roles, with outcomes used to inform wider practice.
  - Leadership days, supervision structures, and working groups for defining sufficient leadership time.

2. Monitoring and Review

- **eRoster and SafeCare Reporting:**
  eRoster and SafeCare systems provide reports for service and clinical governance review, allowing for oversight of how protected time is being used and whether it is sufficient.
    - Reports are reviewed at governance meetings, and adjustments are made as needed to ensure compliance and address any gaps.
- **Governance and Feedback:**
  Clinical governance groups and performance structures provide regular oversight, allowing for escalation of issues and review of compliance.
    - Feedback from staff and governance forums is used to identify areas where additional time or resources may be needed.

3. Addressing Challenges and Continuous Improvement

- **Triumvirate Model and Role Clarity:**
  Work is ongoing to develop and embed the triumvirate model (Professional Lead, Operational Lead, Clinical Lead) in clinical areas, clarifying responsibilities and ensuring adequate time is allocated for each role.
    - In areas where the process to identify clinical leaders is not fully established, efforts are underway to work with all staff groups and use HR processes and eRostering to ensure all relevant individuals are identified and supported.
- **Flexibility and Adaptation:**
  Where additional time is required (e.g., to support HR processes or address workload spikes), clinical leaders can flex their time allocation, with adjustments made through job planning and ongoing monitoring. Ensuring adequate administrative support to prevent erosion of leadership capacity (e.g., physician rota admin reinstated).

4. Service-Specific Examples

- **Maternity:**
  Staff in leadership roles have an agreed split in their hours for leadership and clinical duties, with flexibility to support HR processes as needed. Monthly leadership days and 360 reviews support ongoing development.
- **Women & Children:**
  Nursing leads have protected time for supervision and support, with risk assessments and job planning ensuring a safe balance between workload and workforce.

- **Healthcare Science/Audiology:**
  Clinical leads have time allotted within job plans, reviewed annually, and can adjust as needed based on service demands and individual staff assessments.

Demonstrating Compliance

- **Protected time for clinical leaders is planned, allocated, and monitored using eRoster and job planning.**
- **Regular review and feedback mechanisms ensure time and resources remain sufficient and are adapted as needed.**
- **Governance structures provide oversight and escalation routes for any issues or gaps.**
- **Service-specific adaptations and ongoing improvement work ensure all clinical leaders are supported in fulfilling their responsibilities.**

In summary:
NHS Forth Valley ensures that clinical leaders have sufficient time and resources to supervise patient care, manage and develop staff, and lead the delivery of safe, high-quality, person-centred health care. This is achieved through structured job planning, protected time allocation, regular monitoring, governance oversight, and continuous improvement.

Please provide Information on your methods of monitoring compliance with Duty 12IH
This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

1. Digital Systems and Job Planning

- **eRoster and SafeCare:**
  NHS Forth Valley uses eRoster and SafeCare to allocate, monitor, and report on protected time for clinical leaders (e.g., Senior Charge Nurses, Team Leaders, Heads of Service).
  - eRoster records the split between clinical and non-clinical time (e.g., SCNs are allocated 60% non-clinical time for leadership and management duties).
  - Reports from these systems are regularly reviewed at service and clinical governance meetings to ensure that protected time is being used as planned and to identify any gaps.

- **Job Planning:**
  Job plans for clinical leaders are reviewed annually (or more frequently if needed) to ensure that sufficient time is allocated for supervision, staff development, and leadership responsibilities. Adjustments are made as required based on service needs and feedback.

2. Governance and Oversight

- **Clinical Governance Groups:**
  Regular meetings of clinical governance groups and performance structures provide oversight of compliance with Duty 12IH.
  - These groups review eRoster and SafeCare reports, discuss any issues with protected time, and escalate concerns if clinical leaders are unable to fulfil their responsibilities due to lack of time or resources.
  - Feedback from staff and governance forums is used to identify areas where additional time or support may be needed.
- **Escalation Mechanisms:**
  If non-compliance is identified (e.g., clinical leaders not receiving their allocated protected time), this is escalated through the governance structure.
  - Issues can be raised at team meetings, through line management, or via formal governance routes.
  - Persistent or significant issues are escalated to senior management or the Health Board for resolution.

3. Continuous Improvement and Adaptation

- **Triumvirate Model:**
  NHS Forth Valley is developing and embedding the triumvirate model (Professional Lead, Operational Lead, Clinical Lead) in clinical areas to clarify responsibilities and ensure adequate time is allocated for each role.
  - Ongoing work with HR and eRostering teams ensures that all relevant individuals are identified and supported.
- **Flexibility:**
  Where additional time is required (e.g., to support HR processes or address workload spikes), clinical leaders can flex their time allocation, with adjustments made through job planning and ongoing monitoring.

4. Addressing Non-Compliance

- **Review and Action:**
  If it is identified that clinical leaders are not receiving sufficient time or resources, actions are taken to address this, such as:
  - Reviewing and adjusting job plans.
  - Allocating additional support or resources.
  - Escalating persistent issues to senior management or the Health Board.
- **Feedback Loops:**
  Staff are encouraged to provide feedback on their ability to fulfil leadership responsibilities, and this feedback is used to inform ongoing improvements.

In summary:
NHS Forth Valley monitors compliance with Duty 12IH through a combination of digital systems, job planning, governance oversight, escalation mechanisms, and continuous improvement. These arrangements ensure that clinical leaders have the time and resources needed to supervise care, support staff, and lead high-quality, person-centred services. Persistent or significant issues are escalated and addressed through established governance structures.

Area of Success / Achievement / Learning	Details	Further Action
Working Group on Protected Time (AHPs, Senior Physiotherapists, Team Leaders)	Senior physiotherapists and team leaders convened a working group to determine what sufficient time, and resources would look like for individuals with lead clinical professional responsibility. The outcome was a clear determination of time and resources for different team leaders, with positive feedback from participants.	The positive outcome has led to this model being extended to other Allied Health Professional (AHP) areas and is being trialled to assess applicability and impact across the wider service.
eRoster Implementation for Protected Time (Nursing, Acute Services, Women & Children)	eRoster is used to allocate and monitor protected time for clinical leaders, such as Senior Charge Nurses (SCNs), who are allocated 40% non-clinical time for leadership and management duties. This ensures leaders can supervise, support staff, and lead service improvements.	Ongoing review of eRoster data and job plans to ensure protected time is maintained and adjusted as needed. The approach is being shared with other directorates to standardise best practice.

Area of Success / Achievement / Learning	Details	Further Action
Leadership Days and 360 Reviews (Maternity, Women & Children)	Monthly leadership days and 360-degree reviews have been introduced for midwifery and directorate staff. These initiatives support leadership development, peer learning, and reflection on time/resource allocation.	The leadership day model and 360 reviews are being evaluated for effectiveness and may be rolled out to other clinical areas if proven beneficial.
Non-Caseload Holding Leads (Health Visiting, School Nursing, Immunisation)	Nursing leads in these areas are non-caseload holding, ensuring they have protected time to supervise, support, and lead their teams. This has improved oversight and staff development.	The non-caseload holding model is being reviewed for potential adoption in other services where leadership demands are high.
Flexible Job Planning (Healthcare Science/Audiology, Medicine)	Clinical leads have time allotted within job plans, reviewed annually, and can adjust as needed based on service demands and individual staff assessments. This flexibility ensures leaders can respond to changing needs.	Lessons from flexible job planning are being shared across departments to support responsive leadership and workforce planning.

Area of Escalation / Challenge / Risk	Details	Further Action
Identifying Clinical Leaders Consistently (All Services)	The process in place to identify the roles, and therefore individuals, with lead clinical professional responsibility for a team of staff does not always consistently identify who these individuals are. As a result, sufficient time and resources for these individuals to discharge their responsibilities may not always be considered or allocated.	Work is ongoing with all staff groups, clinical areas, and teams to clarify job titles and roles. HR processes and eRostering are being used to identify team leaders and ensure all relevant individuals are recognised and supported.
Variability in Protected Time Allocation (Acute Services, Advanced Practice)	There is variability across services and disciplines in how protected time for clinical leaders is allocated and maintained. Some areas have robust systems, while others are still developing processes to ensure leaders have adequate time for their responsibilities.	Ongoing review of eRoster data and job plans to ensure protected time is maintained and adjusted as needed. Sharing best practice and standardising approaches across directorates.
Balancing Clinical and Leadership Duties (Healthcare Science/Audiology, Medicine and Maternity)	Clinical leaders sometimes lose protected leadership time due to the need to cover clinical duties, especially during staff absences or high demand. This can impact their ability to fulfil leadership and management responsibilities.	If leadership time is lost due to clinical cover, this is noted in eRoster or job planning tools. Teams are encouraged to review and adjust diaries, allocate additional support, and escalate persistent issues through governance structures.

Area of Escalation / Challenge / Risk	Details	Further Action
Embedding the Triumvirate Model (All Services)	The triumvirate model (Professional Lead, Operational Lead, Clinical Lead) is still being developed and embedded in some clinical areas, leading to occasional ambiguity in responsibility and time allocation.	Continued development and communication of the triumvirate model, with clear role definitions and time/resource allocation. Regular feedback and review to ensure the model is effective and consistently applied.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12II: Duty to ensure appropriate staffing: training of staff.

Duty Summary	**In complying with the duty imposed by section 12IA, every Health Board and the Agency must ensure that its employees receive—** (a) such training as it considers appropriate and relevant for the purposes set out in section 12IA(1)(a) and (b), and (b) such time and resources as it considers adequate to undertake such training.

Please provide information on the steps taken to comply with Duty 12II.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

1. Provision of Appropriate and Relevant Training

- **Mandatory and Role-Specific Training:**
  All staff are required to complete mandatory training relevant to their roles, including statutory and essential modules (e.g., infection control, safeguarding, moving and handling, violence and aggression).
  - Training needs are identified through Personal Development Plans (PDPs), job planning, and annual appraisals.
  - Role-specific training is provided for clinical and non-clinical staff, with additional modules for those in leadership or specialist roles.
- **Induction and Ongoing Development:**
  All new employees undergo a structured induction programme, which includes core training and orientation to local policies and procedures.
  - Ongoing professional development is supported through access to e-learning platforms (e.g., TURAS Learn, NHS FV Learning Zone), face-to-face sessions, and practice development facilitators.

2. Ensuring Adequate Time and Resources for Training

- **Protected Learning Time:**
  Staff are allocated protected time within their work schedules to complete mandatory and developmental training.
  - eRoster is used to plan and record protected learning time, ensuring staff can access training without impacting service delivery.

- In Maternity, for example, 16 hours per staff member are allocated for e-learning, and ad hoc opportunities on shift are also utilised.

- **Monitoring and Reporting:**
  Compliance with mandatory training is monitored through digital dashboards (e.g., TURAS, Pentana), with regular reports reviewed at workforce governance and clinical governance meetings.
  - Training activity, cancellations, and postponements are tracked, and action plans are implemented to address any gaps in compliance.

3. Support for Professional Development and Succession Planning

- **Talent Management and Succession Planning:**
  NHS Forth Valley supports career development through programmes such as “Step into my Shoes,” “Leading to Change,” and national succession planning initiatives.
  - Leadership and management development programmes are available at multiple levels, with cross-board mentoring and coaching opportunities.
- **Practice Development and Education Facilitators:**
  Dedicated facilitators in nursing, medical, and AHP teams deliver training, support PDPs, and ensure staff are up to date with required competencies.

4. Continuous Improvement and Feedback

- **Feedback Mechanisms:**
  Staff feedback on training is collected through surveys, focus groups, and governance forums, and is used to improve training content and delivery.
  - Training needs analysis is conducted regularly to ensure programmes remain relevant and effective.
- **Addressing Non-Compliance:**
  Areas of low compliance are identified through monitoring, and targeted interventions (e.g., additional sessions, reminders, support from line managers) are implemented to address these.

Demonstrating Compliance

- **Training is planned, delivered, and monitored using digital systems (TURAS, eRoster, Pentana).**
- **Protected time for training is allocated and recorded, with compliance reviewed at governance meetings.**
- **Professional development is supported through structured programmes and dedicated facilitators.**
- **Continuous improvement is driven by staff feedback and regular review of training needs and compliance data.**

In summary:
NHS Forth Valley ensures all staff receive appropriate and relevant training, with adequate time and resources to undertake it. Compliance is monitored through robust digital systems and governance processes, and continuous improvement is supported by staff feedback and targeted interventions.

Please provide Information on your methods of monitoring compliance with Duty 12II

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

1. Digital Systems for Tracking Training Compliance

- **TURAS Learn and eRoster:**
  NHS Forth Valley uses the TURAS Learn platform and eRoster to record, monitor, and report on staff training compliance.
  - TURAS provides dashboards for mandatory and role-specific training, allowing managers to track completion rates and identify gaps.
  - eRoster is used to allocate and record protected learning time, ensuring staff can access training during work hours.
- **Pentana System:**
  The Pentana system is used to monitor training activity, cancellations, and postponements, with reports available for review at governance meetings.

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2. Governance and Oversight

- **Workforce Governance Groups:**
  Regular meetings of workforce governance groups and clinical governance structures provide oversight of training compliance.
  - These groups review TURAS, eRoster, and Pentana reports, discuss areas of low compliance, and escalate concerns as needed.
  - Training compliance is also reported through infection control and public protection reports.
- **Practice Development and Education Facilitators:**
  Dedicated facilitators in nursing, medical, and AHP teams support training delivery, monitor compliance, and provide targeted interventions where gaps are identified.

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3. Escalation and Addressing Non-Compliance

- **Action Plans:**
  When areas of low compliance are identified, action plans are developed and implemented. These may include:
  - Additional training sessions or reminders.
  - Support from line managers or facilitators.
  - Monitoring of individual and team compliance through regular reports.
- **Feedback Loops:**
  Staff are encouraged to provide feedback on training access and barriers, which is used to inform improvements and address persistent issues.
- **Protected Learning Time:**
  eRoster is used to ensure staff have protected time for training. If staff are unable to access training due to service pressures, this is escalated through line management and governance structures for resolution.

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4. Continuous Improvement

- **Regular Review:**
  Training needs analysis is conducted regularly to ensure programmes remain relevant and effective.
  - Compliance data is reviewed at governance meetings, and feedback from staff is used to improve training content and delivery.

- **Succession Planning and Talent Management:**
  Programmes such as “Step into my Shoes” and “Leading to Change” are monitored for uptake and impact, supporting ongoing professional development.

In summary:
NHS Forth Valley monitors compliance with Duty 12II through robust digital systems, governance oversight, escalation mechanisms, and continuous improvement. These arrangements ensure staff receive the training they need, with protected time and resources, and that any issues are identified and addressed promptly.

Area of Success / Achievement / Learning	Details	Further Action
Improved CPD Recording in Psychology	The psychology department, in conjunction with HR, completed a project to promote more accurate capturing of information relating to continued professional development (CPD) for psychology colleagues. Feedback from employees is that they have found the new system much easier to use and are now recording relevant CPD more consistently.	Allied Health Professional (AHP) colleagues have expressed interest in the new system and are undertaking a project to establish whether they could implement something similar in their own teams.
Protected Learning Time in Maternity	Maternity services have introduced 16 hours of protected e-learning time per staff member, supporting completion of mandatory and role-specific modules. Staff have reported improved access to training and greater confidence in meeting compliance requirements.	The approach is being evaluated for effectiveness and may be rolled out to other directorates if proven beneficial.
Buddy System for New Managers (Psychology)	A buddy system was introduced for new managers in Psychological Services, supporting their learning in relation to training responsibilities and compliance. This has improved induction and confidence among new leaders.	The buddy system is being considered for wider adoption in other professional groups to support leadership development and training compliance.
Monthly Training Monitoring (Healthcare Science/Audiology)	Monthly time is allocated for mandatory and internal/external CPD training. Training is offered to all staff regardless of contracted hours, and compliance is tracked through TURAS and Auditbase.	The model is being shared with other departments to support fair access to training and improve compliance rates across the organisation.

Area of Success / Achievement / Learning	Details	Further Action
Leadership Development Programmes (All Services)	NHS Forth Valley runs local and regional leadership development programmes, including mentoring and coaching, to support staff progression and succession planning. Staff feedback has been positive, with increased uptake and engagement.	Ongoing evaluation and feedback will inform future programme development and potential expansion to additional staff groups.

Area of Escalation / Challenge / Risk	Details	Further Action
Inconsistent Training Processes Across Staff Groups (Healthcare Science, AHPs)	Clearly defined processes and procedures for mandatory and role-specific training exist for some groups (e.g., nursing and midwifery), but are less well established for others, such as healthcare scientists and some AHPs. This leads to variability in training compliance and access.	NHS Forth Valley is working with HR and representatives from healthcare science and AHPs to define appropriate training programmes, assess training needs, and plan for required training. The aim is to standardise processes and ensure all staff groups have equal access to training and compliance monitoring.
Protected Learning Time Not Consistently Available (Acute Services, Advanced Practice)	Some staff, particularly in high-demand or non-digital areas, report difficulty accessing protected learning time due to service pressures or lack of digital rostering.	Ongoing monitoring via TURAS and Pentana; action plans are being developed to promote and track protected learning time. eRoster rollout is being prioritised in these areas to support better planning and compliance.
Variation in Training Compliance Monitoring (All Services)	There is variation in how training compliance is monitored and reported across different services and disciplines. Some areas use digital dashboards, while others rely on manual records.	The organisation is streamlining training compliance recording onto approved systems (TURAS/eESS-OLM) to make tracking and reporting easier and more consistent. Training facilitators are supporting teams to transition to digital monitoring.
Engagement with Training Programmes (Healthcare Science, Advanced Practice)	Not all staff groups are fully engaged with available training programmes, sometimes due to lack of awareness or perceived relevance.	Targeted communication and engagement initiatives are underway to raise awareness of training opportunities and encourage participation. Feedback from staff is being used to tailor training content and delivery.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12IJ: Duty to follow the common staffing method.

Duty Summary	**(1)In relation to health care of a type mentioned in section 12IK, a Health Board or the Agency (as the case may be) must, no less often than at the frequency specified in regulations by the Scottish Ministers, use the common staffing method set out in subsection (2).** **(2) The common staffing method means that a Health Board or the Agency (as the case may be)—** (a) uses the staffing level tool and the professional judgement tool as prescribed in regulations under subsection (3) and takes into account the results from those tools, (b) takes into account, in so far as relevant, any measures for monitoring and improving the quality of health care which are published as standards and outcomes under section 10H (1) by the Scottish Ministers (including any measures developed as part of a national care assurance framework), (c) takes into account— (i) its current staffing levels and any vacancies, (ii) the different skills and levels of experience of its employees, (iii) the role and professional duties, in particular, of any individual with lead clinical professional responsibility for the particular type of health care, (iv) the effect that decisions about staffing and the use of resources taken for the particular type of health care may have on the provision of other types of health care including, in particular, those to which this section does not apply, (v) the local context in which it provides health care, (vi) patient needs, (vii) appropriate clinical advice, (viii) any assessment by HIS, and any relevant assessment by any other person, of the quality of health care which it provides, (ix) experience gained from using the real-time assessment arrangements under section 12IC (1) and the risk escalation processes under sections 12ID and 12IE, (x) comments by patients, and by individuals who have a personal interest in their health care (for example family members and carers within the meaning of section 1 of the Carers (Scotland) Act 2016), which relate to the duty imposed by section 12IA, and (xi) comments by its employees which relate to the duty imposed by section 12IA, (d) identifies and takes all reasonable steps to mitigate any risks, and (e) having followed the steps described in paragraphs (a) to (d), decides what changes (if any) are needed as a result to its staffing establishment, and to the way in which it provides health care.
Please provide information on the steps taken to comply with Duty 12IJ.	

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

1. Use of Staffing Level and Professional Judgement Tools

- NHS Forth Valley uses the prescribed staffing level tools and professional judgement tools for all relevant clinical areas (e.g., adult inpatient, maternity, neonatal, community nursing, emergency care).
- These tools are run at least annually, as required by regulations, and the results are used to inform staffing establishment reviews and workforce planning.
- A dedicated HR Nursing Workforce team supports all relevant clinical areas to ensure the common staffing method (CSM) is applied consistently.

2. Incorporating Quality Standards and Outcomes

- The CSM process considers national and local quality standards, including those published by the Scottish Ministers and any measures developed as part of the national care assurance framework.
- Care assurance audits, clinical governance reviews, and quality improvement initiatives are integrated into the staffing review process.

3. Comprehensive Consideration of Contextual Factors

The CSM process explicitly considers:

- **Current staffing levels and vacancies:** Data from eRoster and SafeCare is used to assess current establishment, vacancies, and predicted absence.
- **Skills and experience:** The review process includes analysis of skill mix, experience, and succession planning.
- **Roles and duties of clinical leaders:** Job plans and role descriptions are reviewed to ensure clinical leaders have time for supervision, management, and leadership.
- **Impact on other services:** Staffing decisions are considered in the context of their effect on other services, with cross-service collaboration where needed.

- **Local context and patient needs:** Local service reviews, patient feedback, and workload analysis are used to tailor staffing to the specific needs of each area.
- **Clinical advice:** Professional judgement and multidisciplinary team input are integral to the process.
- **External assessments:** Any relevant assessments by Healthcare Improvement Scotland (HIS) or other bodies are incorporated.
- **Learning from real-time assessment and risk escalation:** Experience from real-time staffing tools (SafeCare), risk escalation (IR1, governance meetings), and previous CSM cycles is used to inform improvements.
- **Patient and staff feedback:** Comments from patients, carers, and staff are actively sought and considered in staffing reviews.

4. Risk Identification and Mitigation

- Risks identified during the CSM process are recorded, and all reasonable steps are taken to mitigate them.
- Escalation processes are in place for risks that cannot be mitigated locally, with clear routes to senior management and the Health Board.
- Action plans are developed for areas with persistent or severe risks, and progress is monitored through governance structures.

5. Decision-Making and Implementation

- After completing the CSM process, decisions are made about any required changes to staffing establishment or service delivery.
- Changes are communicated to staff, and feedback is sought to ensure the process is transparent and inclusive.
- The impact of changes is monitored, and further adjustments are made as needed.

6. Monitoring and Continuous Improvement

- The application of the CSM is monitored through regular audits, governance reviews, and feedback from staff and patients.
- Training is provided for all staff involved in the CSM process, and learning from each cycle is used to refine and improve future applications.
- The reporting template and escalation plans are regularly reviewed and updated to reflect best practice and regulatory requirements.

Demonstrating Compliance

- **Annual and ad hoc tool runs** are completed for all relevant areas, with results reviewed by clinical and operational leads.
- **Comprehensive reporting** ensures all required factors are considered and documented.
- **Governance oversight** ensures risks are escalated and addressed, and that changes are implemented and monitored.
- **Staff and patient feedback** is actively sought and used to inform ongoing improvements.

In summary:
NHS Forth Valley follows a robust, evidence-based process for applying the common staffing method, ensuring all statutory requirements are met. This includes the use of staffing tools, consideration of quality standards and contextual factors, risk mitigation, transparent decision-making, and continuous improvement—demonstrating full compliance with Duty 12IJ.

Please provide Information on your methods of monitoring compliance with Duty 12IJ

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

1. Scheduled Tool Runs and Reporting

- **Annual and Scheduled Tool Runs:**
  NHS Forth Valley schedules annual (and, where required, more frequent) runs of the staffing level tool and professional judgement tool for all relevant clinical areas (e.g., adult inpatient, maternity, neonatal, community nursing, emergency care).
  - The results are documented using a standardised reporting template, which includes triangulation with quality standards, patient feedback, and workforce data.
  - The reporting template prompts consideration of all statutory factors (current staffing, skill mix, local context, clinical advice, patient and staff feedback, etc.).
- **Governance Review:**
  Completed reports are reviewed by clinical and operational leads, and then escalated through governance structures (e.g., NMAHP Workforce Governance Group, Senior Leadership Team, Executive Leadership Team) for approval and further action.

2. Digital Systems and Audit Trails

- **eRoster and SafeCare:**
  Data from eRoster and SafeCare is used to monitor current staffing levels, vacancies, skill mix, and the impact of staffing decisions.
  - These systems provide audit trails for compliance with the common staffing method and support ongoing monitoring.
- **Care Assurance Audits:**
  Care assurance audits and clinical governance reviews are integrated into the CSM process, providing additional oversight and evidence of compliance.

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3. Escalation and Addressing Non-Compliance

- **Escalation Pathways:**
  If non-compliance or gaps are identified (e.g., tool runs not completed, statutory factors not considered, risks not mitigated), these are escalated through the governance structure.
  - Issues can be raised at team meetings, through line management, or via formal governance routes.
  - Persistent or significant issues are escalated to senior management or the Health Board for resolution.
- **Action Plans:**
  Where risks or non-compliance are identified, action plans are developed and monitored through governance meetings. Progress is tracked, and further escalation occurs if issues are not resolved.

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4. Continuous Improvement and Feedback

- **Learning from Each Cycle:**
  After each CSM cycle, feedback will be sought from staff and patients, and learning will be used to refine the process and reporting template.
  - Training is provided for staff involved in the CSM process, and updates are made to reflect best practice and regulatory changes.

- **Monitoring Impact:**
  The impact of changes made as a result of the CSM process is monitored through ongoing audits, staff and patient feedback, and review of workforce and quality data.

In summary:
NHS Forth Valley monitors compliance with Duty 12IJ through scheduled tool runs, robust digital systems, governance oversight, escalation pathways, and continuous improvement. These arrangements ensure that the common staffing method is applied consistently, statutory requirements are met, and any issues are identified and addressed promptly.

Area of Success / Achievement / Learning	Details	Further Action
Adult Inpatient Services – Staffing Establishment Review	Application of the common staffing method in adult inpatient areas identified that some wards required changes to their staffing establishment, while others had potential for service redesign. These changes are now in progress and will be trialled to monitor outcomes.	Following completion of the tools, decisions will be taken about formal adoption of changes. The process and outcomes will be summarised as case studies to inform training for staff about the use of the common staffing method.
Neonatal Unit – Tool Run and Reporting	The neonatal unit completed a tool run as part of a proof-of-concept test within SafeCare. The outputs are being used to complete the common staffing method and inform future workforce planning.	Awaiting report from the Healthcare Staffing Programme (HSP). The learning from this exercise will be shared with other neonatal and paediatric services.
Emergency Department – Data-Driven Staffing Decisions	The Emergency Department completed a tool run and is verifying/auditing results. The common staffing template was e completed and supported evidence-based staffing decisions.	The outcomes will be reviewed and the approach will be used as a model for other unscheduled care areas.
Community Nursing – Training and Implementation	Community nursing teams are undergoing training and tool runs to implement the common staffing method, ensuring that local context and patient needs are fully considered.	Lessons learned from the training and implementation process will be used to refine future tool runs and support other community-based services.
Maternity – National Tool Development and Testing	The midwifery team is actively participating in the development and testing of a new national workforce tool. Forth Valley is one of the only boards with fully implemented midwifery	The experience and data from Forth Valley has informed national standards and future iterations of

Area of Success / Achievement / Learning	Details	Further Action
	teams, allowing for comprehensive testing across inpatient and community areas.	the tool, benefiting maternity services across Scotland.

Area of Escalation / Challenge / Risk	Details	Further Action
Variation in Staff Engagement with the CSM Process (Community Nursing,)	Some staff groups, particularly in community nursing, have shown lower engagement with the common staffing method process, leading to incomplete data or delayed reporting.	Engagement initiatives are underway, including workshops, regular communication, and involvement of staff representatives in planning. Feedback is being used to tailor the process and improve participation.
Data Quality and Consistency Issues (All Services)	There have been challenges in ensuring the quality and consistency of data collected during tool runs, particularly where manual processes are still in use. This can affect the reliability of staffing establishment reviews.	The rollout of digital tools (e.g., SafeCare, eRoster) is being prioritised, and training is being provided to standardise data collection. Ongoing audits and spot checks are being used to monitor and improve data quality.
Impact of Staffing Decisions on Other Services (Acute Services, Maternity)	Decisions about staffing and resource allocation in one area (e.g., acute services) have sometimes had unintended consequences for other services, such as increased workload or reduced flexibility.	Cross-service collaboration and impact assessments are being built into the CSM process. Regular review meetings are held to discuss and mitigate any negative effects, and adjustments are made as needed.
Delays in Implementing Changes Identified by the CSM (All Services)	In some cases, changes identified by the common staffing method (e.g., establishment adjustments, service redesign) have been delayed due to resource constraints or competing priorities.	Action plans are being developed with clear timelines and accountability. Progress is monitored through governance meetings, and escalation routes are in place for unresolved delays.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12IL: Training and consultation of staff

Duty Summary	**In complying with the duty imposed by section 12IJ, every Health Board and the Agency must—** (a) encourage and support its employees to give views on its staffing arrangements for the types of health care described in section 12IK, (b) take into account and use any such views it receives to identify best practice, and areas for improvement, in relation to such staffing arrangements, (c) train employees (including, in particular, employees of a type mentioned in the third column of the table in section 12IK (1)) using the common staffing method on how to use it (d) ensure that those employees receive adequate time to use the common staffing method, and (e) provide information to employees engaged in the types of health care described in section 12IK about its use of the common staffing method, including about— (i) the results from using the staffing level tool and the professional judgement tool under paragraph (a) of section 12IJ (2), (ii) the steps taken under paragraphs (b), (c) and (d)] of that subsection, and (iii)the results of its decision under paragraph (e) of that subsection.

Please provide information on the steps taken to comply with Duty 12IL.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

1. Encouraging and Supporting Staff to Give Views on Staffing Arrangements

- **Staff Engagement Mechanisms:**
  NHS Forth Valley encourages staff to provide feedback on staffing arrangements through a variety of channels:
  - Regular staff surveys (e.g., iMatter), focus groups, and team meetings.
  - Staff are invited to participate in discussions about the application of the common staffing method (CSM) and to share their experiences and suggestions for improvement.
  - Feedback is also gathered through professional forums, governance meetings, and direct communication with line managers.

2. Using Staff Views to Identify Best Practice and Areas for Improvement

- **Feedback Integration:**
  Views and suggestions from staff are systematically reviewed and incorporated into staffing reviews and CSM cycles.

- Staff feedback is used to identify best practice, highlight areas for improvement, and inform changes to staffing processes.
- Examples include adapting training delivery, refining reporting templates, and adjusting the timing of tool runs based on staff input.

3. Training Employees on the Common Staffing Method

- **Comprehensive Training Programme:**
  All relevant staff, including those in roles specified under section 12IK, receive training on the use of the common staffing method.
  - Training is delivered through a combination of e-learning modules (e.g., TURAS), face-to-face sessions, and on-the-job support from practice development facilitators.
  - Refresher training is provided regularly, and new staff are trained as part of their induction.

4. Ensuring Adequate Time for Staff to Use the Common Staffing Method

- **Protected Time Allocation:**
  eRoster is used to allocate and record protected time for staff to participate in CSM activities, including tool runs, data collection, and training.
  - Managers are responsible for ensuring staff have sufficient time to engage with the CSM process without impacting service delivery.

5. Providing Information to Staff about the Common Staffing Method

- **Transparent Communication:**
  Staff are kept informed about the use of the common staffing method through:
  - Regular updates at team meetings and governance forums.
  - Sharing of results from staffing level and professional judgement tools, including the rationale for decisions and any changes made as a result.
  - Access to reporting templates, guidance documents, and feedback on the outcomes of CSM cycles.

6. Demonstrating Compliance

- **Documentation and Audit:**
  - Records of staff engagement, training attendance, and protected time allocation are maintained and reviewed at governance meetings.
  - Feedback from staff is documented and used to inform continuous improvement.
  - Compliance with Duty 12IL is monitored through regular audits and reporting to the Health Board.

In summary:
NHS Forth Valley has robust systems and processes to ensure staff are engaged, trained, and supported in the use of the common staffing method. Staff feedback is actively sought and used to drive improvement, and clear communication ensures transparency and understanding of the CSM process. Compliance is monitored through documentation, audit, and governance oversight.

Please provide Information on your methods of monitoring compliance with Duty 12IL

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

1. Staff Engagement and Feedback Mechanisms

- **Regular Surveys and Forums:**
  NHS Forth Valley uses staff surveys (e.g., iMatter), focus groups, and team meetings to gather staff views on staffing arrangements and the use of the common staffing method (CSM).
  - Feedback is also collected through professional forums, governance meetings, and direct communication with line managers.
  - Staff are encouraged to raise concerns or suggestions, and these are documented for review.
- **Documentation and Audit:**
  Records of staff engagement, feedback, and consultation activities are maintained and reviewed at governance meetings. This ensures that staff views are systematically considered and acted upon.

2. Training Delivery and Monitoring

- **Training Records:**
  Attendance at CSM training (including e-learning, face-to-face sessions, and induction) is recorded and monitored using digital systems such as TURAS and eRoster.
  - Refresher training and updates are tracked to ensure all relevant staff remain up to date.
- **Protected Time for Training:**
  eRoster is used to allocate and record protected time for staff to participate in CSM activities, including training, tool runs, and data collection.

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3. Governance and Oversight

- **Workforce Governance Groups:**
  Workforce and clinical governance groups review compliance with Duty 12IL, including:
  - Training attendance and completion rates.
  - Staff engagement and feedback data.
  - Issues raised and actions taken in response to staff views.
- **Escalation Mechanisms:**
  If non-compliance is identified (e.g., staff not receiving training, inadequate time for CSM activities, or lack of consultation), this is escalated through governance structures.
  - Issues can be raised at team meetings, through line management, or via formal governance routes.
  - Persistent or significant issues are escalated to senior management or the Health Board for resolution.

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4. Continuous Improvement and Communication

- **Feedback Loops:**
  Staff feedback is used to refine training content, delivery methods, and consultation processes.
  - Outcomes of CSM tool runs, decisions, and changes are communicated back to staff through team meetings, governance forums, and digital updates.

- **Monitoring Impact:**
  The effectiveness of training and consultation is monitored through regular audits, staff feedback, and review of workforce and quality data.

In summary:
NHS Forth Valley monitors compliance with Duty 12IL through robust staff engagement, digital tracking of training and protected time, governance oversight, escalation pathways, and continuous improvement. These arrangements ensure that staff are consulted, trained, and supported in the use of the common staffing method, and that any issues are identified and addressed promptly.

Area of Success / Achievement / Learning	Details	Further Action
Peer-Led Training and Mentoring (Nursing, Acute Services)	Key personnel with extensive experience in the common staffing method were engaged to train and mentor other staff involved in the process. This peer-led approach increased confidence and consistency in applying the method.	These experienced staff now meet regularly in a forum to discuss shared learning and ensure the common staffing method is used consistently across all relevant areas. The forum will be expanded to include new trainers and staff from other directorates.
Staff Feedback Integration (Community Nursing, AHPs)	Staff feedback collected through surveys and team meetings led to improvements in the timing and delivery of common staffing method training, making it more accessible and relevant to different teams.	The feedback process is now embedded as part of each CSM cycle, and lessons learned are shared at governance meetings to inform future training and consultation.
Protected Time for CSM Activities (Maternity, Women & Children)	eRoster is used to allocate and monitor protected time for staff to participate in CSM activities, including training and tool runs. This has improved staff engagement and the quality of data collected.	The approach is being reviewed for wider adoption in other services, with ongoing monitoring to ensure protected time is maintained and effective.
Development of CSM Champions (Allied Health Professions)	AHPs identified and trained CSM champions within teams to support colleagues, answer questions, and promote best practice in using the common staffing method.	The champion model is being evaluated for effectiveness and may be rolled out to other professional groups if successful.

Area of Success / Achievement / Learning	Details	Further Action
Transparent Communication of CSM Results (All Services)	Results from staffing level and professional judgement tools, as well as decisions made following CSM cycles, are shared with staff through team meetings and digital updates. This has increased transparency and staff understanding of the process.	Plans are in place to develop a digital dashboard for staff to access CSM results and related information in real time.

Area of Escalation / Challenge / Risk	Details	Further Action
Lack of Training on the Common Staffing Method (CSM) for Emergency Care Personnel	Issues were identified with a lack of training on the CSM for personnel in emergency care provision, primarily due to time constraints and service pressures. This resulted in some staff not being fully confident or able to participate in CSM tool runs and related activities.	Arranging and delivering targeted training sessions for emergency care staff, including the provision of mentoring from experienced personnel. Job planning is being reviewed to ensure adequate time is available for designated personnel to undertake CSM training and participate in tool runs.
Inconsistent Engagement with CSM Training (Community Nursing, AHPs)	Some staff groups, particularly in community nursing and AHPs, have shown lower engagement with CSM training, leading to gaps in knowledge and inconsistent application of the method.	Engagement initiatives are underway, including tailored workshops, regular communication, and involvement of staff representatives in planning. Feedback is being used to adapt training content and delivery to better meet the needs of these groups.
Protected Time for CSM Activities Not Consistently Available (All Services)	Staff in some areas report difficulty accessing protected time for CSM activities due to workload and staffing pressures, impacting their ability to fully engage with training and consultation processes.	eRoster is being used to allocate and monitor protected time for CSM activities. Managers are being reminded of the importance of ensuring staff have sufficient time for training and participation in CSM cycles.
Communication of CSM Results and Decisions (All Services)	There have been challenges in ensuring all staff are informed about the results of CSM tool runs, decisions made, and changes implemented as a result.	Plans are in place to develop a digital dashboard and enhance communication channels so staff can access CSM results and related information in real time. Team meetings and digital updates are being used to share outcomes and gather feedback.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty Summary	**Guiding principles etc. in health care staffing and planning** (1) In carrying out the duty relating to staffing imposed by section 12IA of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to the guiding principles for health and care staffing. (2) In planning or securing the provision of health care from another person under a contract, agreement or arrangements made under or by virtue of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to— (a)the guiding principles for health and care staffing, and (b)the need for the person from whom the provision of health care is to be secured to have appropriate staffing arrangements in place.

Please provide information on the steps taken to comply with section 2(2) of this Duty.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

1. Overview of Section 2(2) Duty

Section 2(2) requires that, when planning or securing health care provision from another person (e.g., via contract or agreement), NHS Boards must:

- Have regard to the guiding principles for health and care staffing.
- Ensure that the contracted provider has appropriate staffing arrangements in place.

2. Steps Taken to Comply with Section 2(2)

A. Embedding Guiding Principles in Contracting

- **Quality Standards in Contracts:** All primary care service contracts specify quality standards, which are evaluated through inspections and annual audits by the contracts team within the Health and Social Care Partnerships (HSCPs). Clinicians employed by the Health Board attend inspections and verify contractor-submitted documents to ensure high standards of care continue to be delivered.
- **Person-Centred Approach:** Contractors are required to demonstrate a person-centred approach, engaging with cluster leads in the GP community to ensure quality in patient care. Enhanced services are offered to bring care closer to home, supporting the guiding principles of safe, high-quality, and person-centred care.
- **Governance and Oversight:** There is a governance structure within the Health Board to investigate and resolve issues reported via contractors, ensuring compliance with the Health and Care Staffing (Scotland) Act.

B. Ensuring Appropriate Staffing Arrangements

- **Contractor Responsibility:** Contractors are responsible for their own workforce planning, recruitment, retention, roster management, and staff management. However, the Health Board retains responsibility for ensuring continuity of primary care services.
- **Support and Escalation:** The Health Board provides support for recruitment, advertising, and locum cover when contractors face staffing challenges. Issues are escalated through the Programme Board and risk teams as needed.
- **Compliance Monitoring:** Each contract requires practices to comply with the Health and Care Staffing (Scotland) Act. Guidance is shared with contractors, and compliance is monitored through audits and governance structures.

C. Multi-Disciplinary and Integrated Services

- **Multi-Disciplinary Teams (MDTs):** Primary care contractors and allied health professionals work in MDTs to ensure patients access the right care at the right time. Board-funded Primary Care Improvement allocations support this integration.
- **Enhanced Services:** Allied Health Professionals provide support to hospital services through enhanced services, furthering the aim of integrated, high-quality care.

D. Feedback and Continuous Improvement

- **Staff and Service User Feedback:** Mechanisms are in place for collecting and reviewing feedback from both staff and service users, which informs ongoing improvements and ensures services meet the needs of those served.
- **Transparency and Communication:** Open communication regarding staffing decisions is prioritised, fostering trust and collaboration among staff and service users.

3. Demonstrating Compliance: Evidence and Assurance

- **Audit and Inspection:** Regular audits and inspections of contractors ensure adherence to quality standards and appropriate staffing.
- **Governance Structures:** Issues are escalated and resolved through established governance processes, including the Primary Care Programme Board and risk registers.
- **Support Mechanisms:** The Health Board provides practical support to contractors facing staffing challenges, ensuring continuity of care.
- **Training and Guidance:** Contractors receive guidance on compliance with the Act, and their processes are reviewed during audits.
- **Feedback Loops:** Staff and patient feedback mechanisms are embedded in service delivery and improvement cycles.

Conclusion

NHS Forth Valley demonstrates compliance with section 2(2) of the Duty by embedding the guiding principles in all contracts, ensuring contractors have robust staffing arrangements, providing governance and support, and maintaining continuous monitoring and improvement processes. These systems collectively ensure that both the letter and spirit of the Health and Care Staffing (Scotland) Act are upheld in all contracted health care provision.

Please provide Information on your methods of monitoring compliance when planning and securing services

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

Methods of Monitoring Compliance

1. Contractual and Governance Oversight

- **Quality Standards in Contracts:** All contracts for primary care and other commissioned services specify clear quality standards. These are monitored through regular inspections and annual audits by the contracts team within the Health and Social Care Partnerships (HSCPs).

- **Clinical Verification:** Clinicians employed by the Health Board attend inspections and verify contractor-submitted documents to ensure high standards of care and compliance with staffing requirements.

2. Routine Auditing and Reporting

- **Annual and Ad Hoc Audits:** Audits are scheduled annually and as needed to review compliance with contractual obligations, including staffing arrangements.
- **Service Reviews:** Service redesigns and reviews are conducted to ensure that staffing levels and service delivery remain aligned with statutory requirements.

3. Feedback and Data Collection

- **Staff and Service User Feedback:** Mechanisms such as surveys, focus groups, and feedback forms are used to gather input from staff and service users. This feedback is reviewed regularly to identify areas for improvement.
- **Incident Reporting:** Systems like Safeguard (IR1) are used to report adverse events, including those related to staffing. These reports are analysed for trends and compliance issues.

4. Real-Time Monitoring Tools

- **eRostering and Safecare:** These digital tools provide live analysis of staffing data, enabling real-time monitoring of staffing levels and compliance. They are being rolled out across nursing, AHP, and medical teams.
- **Twice Daily Huddles:** Inpatient nursing and other teams hold regular huddles to review staffing levels and risks, ensuring immediate action can be taken if issues arise.

Local Arrangements for Monitoring Compliance

- **Governance Structures:** Issues of compliance are escalated through established governance processes, including the Programme Board, Workforce Governance Groups, and Senior Leadership Teams.
- **Risk Registers:** Severe or recurring risks are recorded on risk registers and reviewed regularly at governance meetings.
- **Escalation Pathways:** Clear escalation pathways are in place for addressing non-compliance. For example, sustainability risks with contractors are escalated through the Health Board's governance structure, and support is provided (e.g., locum cover, recruitment drives).

- **Reporting Templates:** The Common Staffing Method (CSM) reporting template is used to triangulate findings and escalate concerns as needed.

Mechanisms for Escalating and Addressing Non-Compliance

- **Escalation to Senior Teams:** Issues identified during audits, inspections, or routine monitoring are escalated to senior clinical and operational leads for resolution.
- **Support and Intervention:** The Health Board provides practical support to contractors and internal teams facing compliance challenges, such as additional recruitment resources or temporary cover.
- **Continuous Improvement:** Feedback loops ensure that lessons learned from incidents or audits are incorporated into future planning and service delivery.
- **Risk Mitigation:** Where risks cannot be fully mitigated at the service level, they are escalated to Board level for strategic intervention.

In summary: NHS Forth Valley uses a combination of contractual oversight, routine audits, real-time digital tools, feedback mechanisms, and robust governance structures to monitor compliance when planning and securing services. Clear escalation pathways ensure that any areas of non-compliance are addressed promptly and effectively.

Area of Success / Achievement / Learning	Details (NHS Function / Professional Group)	Description of Situation	Further Action / Future Use
Embedding Act Requirements in Contracts	Contracts Team, Primary Care, HSCP	When procuring from primary care contractors (e.g., GPs, dentists, pharmacies), requirements of the Health and Care Staffing (Scotland) Act are explicitly included in contracts and monitored through audits and inspections.	The approach and contract templates are being adapted for use in other procurement processes, such as with private hospitals and third-sector providers, ensuring consistency in compliance.

Area of Success / Achievement / Learning	Details (NHS Function / Professional Group)	Description of Situation	Further Action / Future Use
Governance and Escalation Structures	Contracts Team, Programme Board, Risk Team	Clear escalation pathways are in place for addressing non-compliance or sustainability risks with contractors. Issues are escalated to the Programme Board and risk registers, with support provided as needed.	The escalation model is being shared with other directorates to standardise risk management and escalation across all commissioned services.
Audit and Inspection Processes	Contracts Team, Clinical Leads	Annual and ad hoc audits of contractors' compliance with staffing and quality standards, including site visits and document verification.	Audit frameworks are being refined and standardised for use in all procurement and contracting activities, including new service models.

Area of Escalation / Challenge / Risk	Details (NHS Function / Professional Group)	Description of Situation	Further Action / Actions Taken
Assurance on Contractor Staffing	Contracts Team, Primary Care, HSCP	Difficulty in obtaining timely and robust assurance from some independent contractors regarding their staffing arrangements and compliance with the Act.	Engaging directly with service providers to clarify requirements, providing guidance and templates, and escalating persistent issues to the Programme Board. Alternative providers considered if assurance cannot be obtained.
Feedback Mechanism Engagement	All Clinical Services, Contractors	Variable engagement with staff and service user feedback mechanisms, especially among contractors and in newly procured services.	Ongoing communication and training to emphasise the importance of feedback. Sharing best practice examples and integrating feedback requirements into contracts.
Escalation of Sustainability Risks	Contracts Team, Programme Board	Sustainability risks identified with some contractors (e.g., GP practices) due to workforce shortages or financial pressures.	Risks escalated through governance structures, support provided (e.g., locum cover, recruitment drives), and contingency plans developed, including potential Board intervention.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

NHS Forth Valley
Forth Valley NHS Board

14. Allied Health Professions Services
Purpose: This report is for Discussion

Executive Sponsor: Karen Goudie, Executive Nurse Director
Author: Professor Paul Cameron, Director of Allied Health Professions

Executive Summary

This paper provides an overview of three Allied Health Profession-led service developments within NHS Forth Valley that exemplify our commitment to proactive, preventative, and person-centred care. Each of the three service areas—Children's Speech and Language Therapy, Adult Weight Management, and AHP-led Frailty Care in Prisons—demonstrates how NHS Forth Valley is redesigning pathways to remove barriers, improve access, and embed early intervention across the system. The strategies underpinning all three services align fully with the Population Health & Care Strategy, Realistic Medicine, and Value-Based Health & Care principles.

Together, these developments showcase:

- A shift from reactive care to proactive support.
- Strengthened partnerships across education, justice, primary care, and community settings.
- Earlier identification of need, reducing escalation and long-term demand.
- Improved access to specialist interventions for traditionally underserved groups.

These three examples highlight NHS Forth Valley's ongoing commitment to transforming care through integrated, compassionate, and sustainable models.

Action Required

The Forth Valley NHS Board is asked to:

- note the three service examples that demonstrate the impact of transforming care for the population of Forth Valley, and
- consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Equality Impact Assessment

Does this report require an EQIA or Fairer Scotland Duty Assessment? **No**

Population Health & Care Strategy

The Services described in this paper are underpinned by the principles of Value Based Health and Care as outlined below:

- Aligns with Realistic Medicine and Value-Based Health & Care by offering accessible, person-centred care and goal setting. The positive impact on quality of life.
- Offers earlier, upstream, prevention and identification to reduce impact of complex needs.
- Offering significant cost avoidance across the system.
- Prevention of future complex secondary issues due to complex conditions
- Working collaboratively locally, nationally within the NHS and other agencies
- Developing a widely recognised specialist workforce

Climate Change / Sustainability Implications
There are no implications in relation to climate change / sustainability.

Engagement and Communications
Was statutory engagement with stakeholders required? **No**

Appendices

Appendix 1 – Main Report

Spotlight on Services: Allied Health Professions Services

Introduction

This paper outlines three key service developments led by Allied Health Professions within NHS Forth Valley, each reflecting a strong commitment to proactive, preventative, and person-centred care. The areas of focus—Children's Speech and Language Therapy, Adult Weight Management, and Allied Health Professional-led Frailty Care in Prisons—illustrate how NHS Forth Valley is innovating and redesigning care pathways to break down barriers, enhance accessibility, and embed early intervention across the system. These initiatives are fully aligned with the Population Health & Care Strategy, Realistic Medicine, and Value-Based Health & Care principles.

Collectively, these developments demonstrate:

- A transition from reactive responses to proactive, supportive care.
- Enhanced collaboration across education, justice, primary care, and community sectors.
- Earlier identification of need, helping to prevent escalation and manage long-term demand.
- Improved access to specialist interventions, particularly for groups that have traditionally been underserved.

These examples emphasise NHS Forth Valley's continuing dedication to transforming healthcare through integrated, compassionate, and sustainable models of service delivery.

Service Example 1. Redesign of Children's Speech and Language Therapy (SLT) – Population Health and Value Based Care in Action

Children's Speech and Language Therapy in NHS Forth Valley has undergone a radical redesign to address long-standing issues of access, equity and sustainability. The previous clinic-based, referral-led model reached only around 10% of children predicted to have speech, language and communication needs, with those most in need often least likely to attend appointments.

The redesigned model shifts resource upstream towards prevention, early intervention and community-based support. Therapists are now embedded within nurseries and schools, providing easy access to expertise without the need for referral and prioritising relational, person-centred conversations focused on "what matters" to children and families.

This population-based approach has significantly improved access, reduced waiting times, strengthened workforce capacity across education settings and reduced health inequalities. In the last year alone, at least 3,500 children were reached through early help conversations and individualised support, double that of the previous model, while achieving more sustainable use of specialist resources.

Impact Assessments

Summary of impacts: The redesigned model has a positive impact on equality by improving access for families previously described as 'unseen' or disengaged. Delivering support in familiar community settings reduces barriers that existed for families accessing support.

A shift from clinic-based activity to community-based prevention has supported more efficient use of specialist capacity and reduced demand for intensive individualised intervention.

Workforce Implications

Positive impacts:

- Increased job satisfaction through relational and preventative working.
- Enhanced skills for working in education and community settings.
- Stronger partnership working with education staff and families.

Challenges:

- Significant cultural change from traditional specialist models.
- These have been mitigated through strong leadership, workforce development, supervision, reflective practice and a focus on psychological safety and sustainable workloads.

Quality / Patient Care Implications

The model has delivered clear improvements in quality and experience as 97% of children are now seen within 12 weeks (lowest waiting times in Scotland). Thirty-eight percent of families receive support within one week, often via early help conversations. Parent and education partner satisfaction is extremely high, with ratings above 4.8/5. Care is more person-centred, outcome-focused and aligned to what matters to children and families.

Population Health & Care Strategy

The redesigned service directly delivers the Population Health & Care Strategy 2025–2035 priorities:

- Prevention first: early conversations, reassurance and universal environments.
- Community first: support delivered where children are in nurseries and schools.
- People first: child's voice central, shared decision-making.
- Reducing inequalities: embedded approach reaches families previously least likely to access services.

This represents Public Health and Value Based Health & Care in action at a population level.

Service Example 2. Adult Weight Management

Impact Assessments

Equality & Diversity and Fairer Scotland Duty
The 'Dietetic Review' of the Adult Weight Management project underwent an EQIA with Falkirk Health and Social Care Partnership; The EPIA found no required mitigations because accessible referral routes, adapted resources and targeted support were built into the service redesign and delivered in practice. Monitoring demonstrated that these changes improved timeliness and choice without negatively affecting access for SIMD 1-2 groups or the wider demographic profile.

Financial, Digital and Infrastructure Implications
The redesign has generated efficiencies that released capacity within current establishment to undertake work previously not possible, such as targeted inequalities support, without increasing staffing resource. A proportion of activity has also been shifted to a third-party digital provider, improving service continuity and demonstrating good value-based use of resources. Though not generating a direct cost saving the project has resulted in improved use of resource with likely savings to be realised over time via a reduction in use of other health services.

Workforce Implications
The project has reduced operational pressure on staff, with shorter waiting times, clearer processes and digital support for service continuity contributing to reported lower stress levels. Staff have also reported increased job satisfaction and a greater sense of professional development, particularly through their involvement in QI activity and planning of more targeted work in inequalities.

Quality / Patient Care Implications
The new model is delivering strong early outcomes, with 65% of participants choosing to progress into supported pathways, while others opt to manage their weight independently following the information and tools provided. Patients are reporting greater confidence, improved understanding and a clear shift from complaints to compliments. Programme retention at 12 weeks has increased from approximately 60% to 85% in group-based programmes and 82% within the digital app-based programme. Early assessment of weight loss outcomes indicates that those completing the 3-month app-based option (82%) are achieving an average loss of 8.42%, with 44% still engaged at six months achieving 10.69%, compared with previous local delivery outcomes of 3-4%. Our locally delivery remains average weight loss of 3-4% at 3 months however we have seen the percentage of those accessing us with 3 or more comorbidities increase within the new model suggesting an increased complexity. the efficiency gains created through the project will enable the team to begin scoping and delivering targeted inequalities work in our communities which was previously not possible within existing resources.

Population Health & Care Strategy
Contributes to Preventing Ill Health, Value Based Health and Care, Developing our Workforce and the efficiency gains will allow us to have increased action in Working Collaboratively and Reducing Inequalities.

Service Example 3: Allied Health Professional-led Frailty Care in Prisons

The Forth Valley Speech and Language Prison service, established in 1968, is the oldest known service of this type.

Around 75% of individuals in custody have Speech, Language and Communication Needs (SLCNs), contrasted with around 7% of the general population. The Prisons Speech and Language Therapy service is delivered in a tiered model of Universal, Targeted and Individualised inputs. Service requirements evolve with the changing prison population. For example, dysphagia (eating and drinking issues, also managed by SLTs) were once rarely encountered, now they are a significant element of our caseload.

Impact Assessments

The introduction of the Speech and Language Rapid Frailty clinic has eliminated sustained waits for frail and medically vulnerable patients in prison.

Average waiting times have decreased from 11 weeks to <1 week. Patients report a high level of satisfaction with the service.

The shift to an anticipatory approach ensures that we are able to provide timely, responsive care to patients who a vulnerable due to their clinical needs and their environment. EDS (Eating, Drinking and Swallowing) and Communication plans are enacted at the time of first contact. Assessing patients in the residential halls allows immediate collaboration with carers, residential staff and peer supporters. Early management of dysphagia has the potential to reduce hospital admissions for chest infections/aspiration pneumonia.

NHS Forth Valley

Forth Valley NHS Board

15. Finance Report
Purpose: This report is for Assurance

Executive Sponsor: Ross McGuffie, Chief Executive
Author: Scott Urquhart, Director of Finance / Jillian Thomson, Deputy Director of Finance

Executive Summary

This report provides a summary of the draft financial outturn position for the 12-month period ending 31st March 2026. The draft outturn indicates that all 3 statutory financial targets set by Scottish Government were met, as summarised below:

- A surplus of £0.245m against the revenue resource limit of £1,003.1m.
- A break-even position against the capital resource limit of £13.4m
- A break-even position against the cash requirement with a closing bank balance of less than £0.050m.

The draft outturn is consistent with the forecast year-end position previously reported to the NHS Board. The draft outturn is subject to change, pending the outcome of the external audit of the 2025/26 Annual Accounts, receipt of the final allocation letter from the Scottish Government and confirmation of both IJB outturns (financial risk share payments to IJBs have been incorporated in the draft outturn position based on latest estimated outturn positions).

Preparation of the 2025/26 Annual Accounts is well underway, and an initial draft will be submitted to the NHS Board's External Auditor on 1st May 2026. The final audited accounts will be considered by both the Audit and Risk Committee and the NHS Board on 16th June 2026.

The NHS Forth Valley Financial Plan for 2026/27 was approved by the NHS Board and by Scottish Government in March 2026. It is important that we continue to prioritise strong financial discipline and build early momentum on savings delivery in the first quarter of the new financial year.

Budget managers have been asked to focus on securing early savings, maintain tight control on budget management, and to progress actions for named leads aligned to revised 15-box grid programmes, scrutinised through the Financial Stewardship Programme Board. A practical aid to support effective management and use of resources, including guidance, prompts and examples, has been made available on the staff intranet for managers and leaders to support them in delivering these actions.

Action Required

Forth Valley NHS Board is asked to:

(1) Note that the draft outturn for financial year 2025/26 indicates that the NHS Board has met all 3 statutory financial targets.
(2) Note that the draft outturn remains subject to External Audit review, receipt of the final Scottish Government budget allocation letter and confirmation of IJB year-end positions.

(3) Consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration
The SPP&RC and the NHS Board receive regular updates on the financial position, plans and risk as a standing agenda item.

Risk Assessment and Mitigation
Financial sustainability continues to be reported as very high risk in the NHS Board's strategic risk register. This reflects the financial impact of ongoing operational service and demand pressures.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty
Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial and Infrastructure Implications
The Capital and Revenue financial implications are considered in the main body of the report.

Workforce Implications
There are no immediate workforce implications associated with this report. However, it is recognised that workforce costs account for a significant proportion of total operating expenditure and is therefore a key financial risk area.

Quality / Patient Care Implications
It is imperative that quality of care and overall service provision is underpinned by a sustainable financial strategy aligned to the principles of Value Based Health and Care.

Population Health & Care Strategy
It is recognised that improving population health outcomes and shifting resources to early intervention/more preventative measures can reduce future demand on services. Adopting the principles of values-based health and care and Realistic Medicines is a key feature of our financial planning process.

Climate Change / Sustainability Implications
There are no direct climate change/sustainability implications arising from this report. Climate Change and Sustainability initiatives contribute to efficiency savings, reducing waste, cost avoidance and productivity gains across the five priority areas for NHS Scotland (i.e. Sustainable Buildings & Land; Sustainable Travel; Sustainable Goods & Services; Sustainable Care; and Sustainable Communities). A range of climate change and sustainability initiatives are already included in our cost improvement programme.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒
This report was prepared in consultation with Senior Finance colleagues.

Appendices
Appendix 1 – Overview of 2025/26 outturn

Appendix 1 - Overview of 2025/26 outturn

1. NHS FV Financial Performance

A small underspend of £0.245m is reported for the 12-month period ended 31 March 2026 against a total RRL of £1.0 billion (subject to external audit review) as summarised in table 1 below.

TABLE 1: NHS Forth Valley 2025/26 Finanical performance	Annual Budget £m	April - March Budget £m	April - March Expenditure £m	Underspend/ (Overspend) £m
Set Aside & Non-Delegated Functions*				
Acute Services	268.971	268.971	283.048	(14.077)
Woman Children and Families	68.274	68.274	69.259	(0.985)
Cross Boundary Flow/External SLAs	76.033	76.033	75.303	0.730
Non-delegated Community Services	43.606	43.606	45.183	(1.577)
Facilities	121.772	121.772	121.102	0.671
Digital	27.196	27.196	26.681	0.515
Corporate Functions	58.969	58.969	56.843	2.126
Ringfenced and Contingency Budgets	13.027	13.027	0.000	13.027
Income	(47.914)	(47.914)	(47.729)	(0.185)
Sub total	**629.934**	**629.934**	**629.689**	**0.245**
Delegated Functions				
Operational Services	152.360	152.360	143.983	8.377
Universal Services	198.311	198.311	205.229	(6.918)
IJB reserves	23.998	23.998	23.998	(0.000)
Sub total	**374.669**	**374.669**	**373.210**	**1.459**
Reserve transfers (to)/from IJB				
Clackmannanshire & Stirling IJB	0.752	0.752	0.000	0.752
Falkirk IJB	(2.211)	(2.211)	0.000	(2.211)
Sub total	**(1.459)**	**(1.459)**	**0.000**	**(1.459)**
TOTAL	**1,003.145**	**1,003.145**	**1,002.899**	**0.245**

* Note that these budgets include specialties defined as "large hospital services" which form part of IJB Set Aside budgets. The total Set Aside budget included in the total of £629.934m above is £88.8m. An overspend of £9.074m is reported at month 12.

Despite the favourable outturn position reported in table 1 above, significant financial challenges were experienced across the whole health and care system during the course of the year as a result of:

- Pay pressures relating to medical staffing (reflecting ongoing agency use and rota compliance) together with high unregistered nurse staffing costs (linked to unfunded service areas and cover for sickness absence).
- increases in the cost of medicines and devices (particularly in relation to the uptake of new drugs and devices including oncology drugs, hep C medication and diabetes technology such as insulin pumps and continuous glucose monitors);
- the impact of unavoidable inflationary pressures on a range of contracts, particularly relating to IT and premises.

- Delays in the pace of delivering efficiency savings (with the overall savings plan c£11.2m behind target at the end of the year).

During the course of the year temporary workforce costs amounted to £29.5m (down £6.5m or 18.2% on the previous year) as summarised in table 2 below. This was largely driven by the positive impact of ongoing actions relating to temporary nursing costs which reduced by £5.0m.

Table 2: Non-Core Staffing Costs	Apr 24 to Mar 25 £	Apr 25 to Mar 26 £	Better/ (Worse) £	% Change
Admin agency	41,105	11,744	29,361	71.4%
Admin bank	1,222,586	1,114,388	108,198	8.8%
Medical agency	4,801,943	4,119,955	681,989	14.2%
Medical bank	2,591,132	3,303,556	(712,423)	(27.5%)
Medical locum	2,292,101	1,307,837	984,264	42.9%
Nurse agency	2,398,451	18,832	2,379,618	99.2%
Nurse bank	19,412,726	16,738,858	2,673,869	13.8%
Other agency	298,118	313,816	(15,698)	(5.3%)
Other bank	1,345,605	1,236,578	109,027	8.1%
Overtime	1,656,168	1,329,800	326,368	19.7%
Total	**36,059,936**	**29,495,364**	**6,564,572**	**18.2%**

At this stage the final outturn position for delegated services has not yet been confirmed by the IJBs, however the latest forecast data provided by the Chief Finance Officers indicates that an additional risk share payment is required for Clackmannanshire and Stirling IJB (£1.6m has been accounted for in the draft outturn over and above the £4.0m previously agreed for 2025/26). No change to Falkirk IJB with the risk share payment remaining at £1.9m for 2025/26.

2. Efficiency Savings

A £38.1m savings target was identified for 2025/26 (£21.9m recurring and £16.2m non-recurring). During the course of the year total savings of £26.9m were delivered as summarised in table 3 below. Note that unachieved recurring savings will be carried forward to 2026/27.

Of the £26.8m total saving achieved to date, £19.4m (72%) was classed as recurring, largely due to the ongoing impact of nurse agency reductions and prescribing savings through implementation of a range of technical drug switches and the review of stock management and off contract spend.

Despite the positive action taken to date, savings delivery was £11.2m behind plan as at 31 March 2026. This is largely due to delays in the redesign of unfunded services, contractual issues relating to energy efficiency schemes and ongoing non-compliant rotas and high sickness absence levels in certain service areas.

Annual plan £m	TABLE 3: 2025/26 Finanical Sustainability Action Plan - YTD saving delivery	Apr - Mar plan £m	Apr - Mar actual £m	Variance £m
	15 Box Grid: Innovation & Value-Based Healthcare			
0.035	Clinical Variation Review	0.035	0.024	(0.011)
0.392	Digital savings	0.392	0.134	(0.258)
1.965	Energy Efficiency Schemes	1.965	0.655	(1.310)
3.691	Prescribing savings	3.691	4.609	0.918
6.083	**Sub total: Innovation & Value-Based Healthcare**	**6.083**	**5.422**	**(0.661)**
	15 Box Grid: Workforce Optimisation			
0.999	Agency Reduction	0.999	3.061	2.062
4.949	Sustainable staff bank usage	4.949	2.740	(2.209)
0.500	Sickness absence reduction	0.500	0.000	(0.500)
1.044	Non-compliant rotas review	1.044	0.000	(1.044)
0.000	Central functions job family review	0.000	0.000	0.000
7.492	**sub total: Workforce Optimisation**	**7.492**	**5.801**	**(1.691)**
	15 Box Grid: Service Optimisation			
0.500	Theatres optimisation	0.500	0.051	(0.449)
1.909	Remote outpatient appointments	1.909	0.000	(1.909)
0.200	PLICS roll out	0.200	0.200	0.000
0.000	Length of stay reductions	0.000	0.000	0.000
0.221	Non-pay spend review	0.221	0.130	(0.091)
2.830	**sub total: Service Optimisation**	**2.830**	**0.381**	**(2.449)**
	Other local savings plans			
2.482	Estates & Infrastructure	2.482	1.467	(1.015)
8.603	Service redesign & reform	8.603	1.468	(7.135)
10.409	Non-pay & other measures	10.409	12.150	1.741
0.163	Savings under development	0.163	0.120	(0.043)
21.657	**sub total: Other local savings plans**	**21.657**	**15.206**	**(6.451)**
38.062	**TOTAL**	**38.062**	**26.810**	**(11.252)**
21.899	Recurring	21.995	19.351	**(2.644)**
16.163	Non-recurring	16.067	7.460	**(8.607)**
38.062	**TOTAL**	**38.062**	**26.810**	**(11.252)**

3. Capital Financial Performance

A balanced position is reported against the CRL of £13.6m as summarised in table 4 below.

TABLE 4: 2025/26 NHS Forth Valley Capital Position	April - March Budget £m	April -March Expenditure £m	Underspend/ (Overspend) £m	Funds Available
Elective Care	0.393	0.393	0.000	0.000
Information Management & Technology	4.176	4.176	0.000	0.000
Medical Equipment	8.166	8.166	0.000	0.000
Facilities & Infrastructure	2.773	2.773	0.000	0.000
NHS Board corporate projects	(0.072)	(0.072)	0.000	0.000
Right of Use Assets IFRS16	0.278	0.278	0.000	0.000
Total Available Capital Funding	**15.715**	**15.715**	**0.000**	**0.000**
Indirect Capital Charged to Revenue	(1.766)	(1.766)	0.000	0.000
ADEL Funded Expenditure	(0.393)	(0.393)	0.000	0.000
Forecast NET Capital Resource Limit	**13.556**	**13.556**	**0.000**	**0.000**

During the course of the year a range of planned capital investment projects were delivered including:

- ongoing advisor and professional fees relating to the National Treatment Centre,
- key information management and technology priorities (including the new Radiology Information System (RIS), upgraded Picture Archiving and Communication System (PACS) and the new Digital Pathology system. Slippage of £1.7m in relation to Order Comms and LIMS replacement was handed back to the Scottish Government due to national delays in these projects. This funding will be returned in 2026/27.
- purchase of new medical equipment including the replacement beds, new Ultrasound Probes and Max Fax dental equipment. A new robotic surgery system was also purchased following an adiitonal allocation of funding from the National Infrastructure Board.
- various facilities and infrastructure projects to improve Dunblane Health Centre, professional fees in relation to the proposed ASDU extension, improvements to the footpaths at the Bungalows, Legionella Remedial works, refurbishment of the Resident Doctors accommodation at FCH and the initial roll out of the anti-ligature works at FVRH.

4. FORWARD LOOK

2026/27 Financial Plan

The Financial Plan for 2026/27 was approved by the NHS Board and by Scottish Government in March 2026.

Based on known and anticipated planning assumptions, the financial plan for 2026/27 forecasts a break-even position. This is dependent on delivery of £38m of savings which includes the impact of recurring pressures and unachieved recurring savings carried forward from 2025/26. Achieving savings on this scale will require sustained organisational focus and the continued application of rigorous financial controls, alongside detailed scrutiny of the in-year financial position. It is important that we continue to prioritise strong financial discipline and build early momentum on savings delivery in the first quarter of the new financial year.

A number of cost improvement plans and efficiency initiatives have been developed to mitigate the £38m gap and deliver breakeven. As previously reported, implementation of the savings plan will be overseen by the Financial Stewardship Programme Board with regular progress updates provided to the SPP&R Committee.

Emerging risks

Several new and emerging risks have been identified at this early stage in the 2026/27 financial year linked to:

- Continuing uncertainty regarding the cost of AfC reform (particularly in relation to the reduction in the working week and the review of band 5 nursing job profiles). Our current planning assumption is that all AfC reform costs will be fully funded by the Scottish Government.

- Ongoing demand for new medicines and technologies beyond available funding levels (including GLP1/weight loss drugs and diabetes technology);
- Delays in the redesign of unfunded service areas;

The position will be kept under close review as the year progresses in a bid to quantify the potential financial impact and identify key mitigating actions where necessary.

NHS Forth Valley

Forth Valley NHS Board

16. Performance Report
Purpose: This report is for Assurance

Executive Sponsor: Ross McGuffie, Chief Executive
Author: Kerry Mackenzie, Acting Director of Strategic Planning & Performance; Claire Alexander, Senior Performance Manager; Garry Fraser, Director of Acute Services; Marie Gardiner, Head of Acute Services; Deborah Lynch, Unscheduled Care, Programme Manager; Fiona Murray, Head of Emergency Care & Inpatients.

Executive Summary

NHS Forth Valley routinely reports performance against a range of non-financial performance metrics. The Performance Report is presented to update the Board in respect of NHS Forth Valley's performance against a range of national and local measures with information provided to support effective monitoring and management of system-wide performance.

The scorecard provides an 'at a glance' view of measures with work on-going to ensure accuracy of data, and that all the definitions and reporting periods remain appropriate and meaningful. The scorecard is continually reviewed to ensure appropriate revisions or amendments are included in a responsive and timely manner.

The overall approach to performance within NHS Forth Valley underlines the principle that performance management is integral to the delivery of quality improvement and core to sound management, governance, and accountability.

Action Required

The Forth Valley NHS Board is asked to:

(1) consider the latest performance data within the Performance Report noting the Area of Focus – Urgent & Unscheduled Care and Priority Areas of Performance.
(2) consider the progress made in reducing the number of patients waiting over 52 weeks for a new inpatient appointment and for an inpatient/daycase procedure.
(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

This paper has previously been considered by the Strategic Planning, Performance & Resources Committee on 31 March 2026 with questions invited.

The increase in delayed discharges as a result of guardianship was discussed with clarity provided around the legal process surrounding this and the resultant impact.

Committee members queried the sustainability of improvements in length of stay. The Committee was advised that the improvements reflect embedded system changes, including Delivery Without Delay, criteria to reside, ward-based discharge coordination, and a strengthened grip on complex discharges.

PDP completion rates and variation across directorates was discussed. The distinction between PDPs signed off and those currently in progress was highlighted with assurance provided that the variable performance across areas was being actively managed through directorate-level review. Oversight was via the Staff Governance Committee.

Clarity on work to improve and sustain the 62-day cancer target performance was requested, specifically around urology. It was noted that there were particular pressures within this area due to staff absence and tertiary service dependencies.

Committee members expressed concern that the urgent and unscheduled care reporting did not provide sufficient assurance against the agreed improvement strategies. This was acknowledged, with confirmation that work would be undertaken with the urgent & unscheduled care team to strengthened reporting aligned to the Rapid Improvement Plan.

Risk Assessment and Mitigation

Adequate monitoring, scrutiny and management of performance supports the organisation to manage its risk with performance reporting linked to Strategic Risks:

SRR.002 Urgent & Unscheduled Care
If NHS Forth Valley does not have enough whole system capacity and flow to address key areas of improvement there is a risk that we will be unable to deliver safe, effective, and person-centred unscheduled care resulting in a potential for patient harm, increases in length of stay, placement of patients in unsuitable places, and a negative impact on patients and staff experience.

SRR.004 Scheduled Care
If NHS FV does not consider and plan for current and future changes to population and associated demand/case-mix, there is a risk that the model for delivery of planned care will not meet demand or prioritise effectively, resulting in poorer patient outcomes, avoidable harm and failure to meet targets.

In addition, there is linkage to Organisational Risks in respect of Waiting Times, Radiology/Imaging Capacity, Delayed Discharge, Mental Health Services – Psychological Therapies and the 62-day cancer target.

These risks are reviewed and updated by the responsible risk owners with the Strategic Risk Register update presented as a standing item to NHS Board Assurance Committees and the NHS Board.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial and Infrastructure Implications

Financial implications and sustainability are being considered on an ongoing basis working closely with Scottish Government colleagues and Health & Social Care

Partnership Chief Finance Officers. The Finance Report is a standing item on the Performance & Resources Committee and Forth Valley NHS Board meeting agendas. Financial Breakeven is detailed on the Strategic Risk Register as a Very High risk for NHS Forth Valley. As such it is reviewed and managed as a risk assigned to the Strategic Planning, Performance & Resources Committee.

SRR.005: Financial Breakeven
If our recurring budget is not sufficient to meet the recurring cost base there is a risk there will be an increasing recurring gap in our finances, resulting in an inability to achieve and maintain financial sustainability, and a detrimental impact on current/future service provision.

Workforce Implications
Workforce is a limiting factor in our ability to delivery services with specific workforce issues aligned to areas of performance highlighted within the report. The Workforce Plan 2026/27 is currently being developed, and it is anticipated that the draft will be presented to the Staff Governance Committee in March ahead of issue in April 2026.

Quality / Patient Care Implications
There are no specific quality or patient care implications in respect of this paper.

Population Health & Care Strategy
Monitoring performance and the ongoing development of relevant performance frameworks will support the monitoring of local and national strategy implementation.

Climate Change / Sustainability Implications
Describe any implications in relation to climate change / sustainability.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

- If yes, please provide details.

Cognisance has been taken of feedback and comments from Non-Executive and Executive Director colleagues.

Appendices
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Performance Report

March 2026

Report format

- The report is split into 4 sections
    - Section 1: Performance Summary
    - Section 2: Area of Focus
    - Section 3: Performance Report
        - Priority Areas of Performance
        - Other Areas of Performance
    - Section 4: Performance Scorecard

- Section 1: Performance Summary
    - Section 1 provides a summary overview of key areas of performance.

- Section 2: Area of Focus
    - Section 1 will focus on a particular area of performance with a detailed discussion in respect of areas of challenge and key areas of improvement.

- Section 3: Performance Report
    - This section details key performance issues, measures, and graphs.
    - Measures, graphs and key performance issues narrative are linked and should be viewed collectively.
    - The Scotland comparison has been included where possible in the Key Performance Measures and Key Performance Graphs sections. Note that the Scotland figures are typically a month or quarter behind.

- Section 4: Performance Scorecard
    - The Performance Scorecard details the measure, target, current position (monthly or quarterly), previous reported position, previous year position and the Scotland position (where available).
    - The notes section provides a definition and detail in relation to the indicators and targets.

Performance data and graphs continue to be developed within the Pentana Performance and Risk Management System with graph and table detail from Pentana informing the report.

Section 1: Performance Summary

Area of Focus – Urgent & Unscheduled Care

February performance reflects early recovery from January winter pressures, with stabilisation across length of stay, occupancy and delayed discharge measures. Front-door congestion and ED flow constraints persist, limiting improvement in the 4-hour standard and contributing to continued waits at peak times.

- **Emergency Department 4-hour Standard**: Forth Valley compliance improved slightly from 56.9% in January to 59.3% in February, remaining well below the required standard. The modest improvement suggests some easing of peak winter pressure.

- **Average Length of Stay (LoS):** Mean emergency LoS reduced to 7.4 days in February, although late-December performance demonstrated the system's ability to achieve significantly lower weekly LoS (6.0 → 5.4 days). Continued focus on discharge reliability is needed to reach the 7.0-day March 2026 trajectory.

- **Hospital Occupancy:** During February, hospital occupancy reduced from the elevated levels seen in January and stabilised closer to the 107.3% mean.

- **Total Delayed Discharges:** Total delayed discharges fluctuated through February with expected week-to-week variation, ending the month at around 113, sustaining an over 20% reduction.

- **Acute Delayed Discharges:** Delayed discharges remained elevated through much of February, with levels above the process mean before returning closer to the mean in the most recent week. Stabilisation reflects retention of earlier gains despite ongoing seasonal pressure, including high demand, constrained community capacity, and a continued cohort of long-stay patients. While deterioration has been avoided, performance remains below the target of a 25% reduction (~25), indicating further improvement is required.

- **Hospital at Home:** Older Adult Hospital at Home utilisation ranged from 80.5% to 88.6% during February. Work continues toward expanding capacity to 112 beds by December 2026.

- **Flow 1 (Minors):** Performance improved in February to 86.0%, recovering from the January position of 84.1%.

- **Time to First Assessment:** Median time increased to 127 minutes, driven by high occupancy and overnight backlog.

- **Pre-noon Discharges:** Decreased to 16.7%, down from 17.7%, but still below the 20% target.

- **Length of Stay greater than 14 days:** Following the sharp seasonal rise in January, the number of patients with a length of stay greater than 14 days reduced during February, showing a sustained improvement from the winter peak.

- **Contingency Beds:** Following the January peak, contingency bed usage reduced and stabilised through February. February had a monthly contingency bed usage of 42 compared with 51 in January.

Priority Areas of Performance

Unscheduled Care
Overall compliance with the 4-hour emergency access standard (EAS) in February 2026 was 59.3%; Minor Injuries Unit 99.5%, Emergency Department 46.9%. A total of 2,527 patients waited longer than the 4-hour target across both the ED and Minor Injuries Unit (MIU); with 1,264 waits longer than eight hours, 582 waits longer than 12 hours and 57 waits longer than 23 hours. The main reason for patients waiting beyond 4 hours continues to be wait for first assessment with a cohort of 1,574 patients, noting this was 1,348 in February 2025. Wait for a bed accounted for 583 patients waiting beyond 4 hours with clinical reasons accounting for 127 breaches. In February there were 437 new attendances to Rapid Assessment and Care Unit (RACU), 91 of which were via ED. It is worth noting 744 patients that attended ED did not wait in February 2026 compared with 588 in February 2025.

Delayed Discharges
The February 2026 census position in relation to standard delays (excluding Code 9 and guardianship) is 53 delays; this is compared to 78 in February 2025. There was a total of 51 code 9 and guardianship delays, with the total number of delayed discharges noted as 104. The number of bed days occupied by delayed discharges (excluding code 9 and 100) at the February 2026 census was 2,146, this is a reduction from 2,436 in February 2025.

Scheduled Care
At the end of February 2026, the number of patients on the waiting list for a first outpatient appointment was 18,291 (17,694 excluding mutual aid) compared with 13,177 in February 2025 with the number waiting beyond 12 weeks 7,415 (7,035 excluding mutual aid) compared to 3,845 in February 2025.

In February 2026, the number of inpatients/daycases waiting was 7,578 (7,256 excluding mutual aid and NTC) compared with 6,873 in February 2025. An increase from the previous year in those waiting beyond 12 weeks from 4,475 to 5,062 was also noted.

At the end of January 2026, 1,082 patients were waiting beyond the 6-week standard for imaging with 47 patients were waiting beyond 6 weeks for endoscopy.

Cancer target compliance in January 2026:

- 62-day target – 77.8% of patients waited less than 62 days from urgent suspicion of cancer referral to first cancer treatment. This is compared with the January 2025 position of 74.4%.
- 31-day target – 100%.

The position for the October to December 2025 quarter is that 70.3% of patients were treated within 62 days of referral with a suspicion of cancer. This is a decrease from 85.9% the previous quarter. During the same period, 99.7% of patients were treated within 31 days of the decision to treat.

Psychological Therapies
In February 2026, draft data shows that 76.6% of patients started treatment within 18 weeks of referral.

Healthcare Guardian

The Senior Leadership Team agreed transition to Ideagen Healthcare Guardian via the NHS National Services Scotland Integrated Incident Risk Management & Patient Safety System (IIRMPSS) Framework at its meeting on Monday 23 February 2026.

This decision confirms NHS Forth Valley's strategic intent to move to an updated single, integrated system for risk, safety, performance, quality and assurance, replacing the current fragmented multi-system landscape.

Healthcare Guardian will replace the Ideagen Risk Management System (Pentana), the incident management system Ulysess (Safeguard) System, the care at bedside audit system (TCAB) and the Moses Morbidity, Mortality & Significant Events system (MoSES).

The transition to Healthcare Guardian enables a single version of the truth across incidents, risks, complaints, audits, safeguarding, performance, projects and assurance. This improves triangulation of information to support Board and Committee assurance, strengthening visibility of risk, control and performance. Healthcare Guardian also supports a more coherent and mature Quality Management System, linking quality planning, assurance, improvement and control. Standardised data visualisation enables consistent use of SPC, run charts, and performance intelligence for evidence-based decision-making across the organisation.

Implementation will be phased over the next 15-to-18-month period with an initial focus on streamlining of processes. An implementation plan is currently being developed with programme support from CPMO colleagues. Oversight of the overall implementation will be through the Senior Leadership Team.

Section 2: Area of Focus Urgent and Unscheduled Care

Urgent and Unscheduled Care Programme – Progress and Assurance March 2026

1. Introduction

This report provides an integrated overview of delivery, progress and assurance across the Urgent and Unscheduled Care (U&UC) programme. It brings together activity across the front door, acute flow, discharge, community pathways and system enablers, reflecting the programme's position following sustained winter pressure and at a point of transition from stabilisation to renewed improvement.

The report describes what has been achieved, how programme capacity and sequencing have been affected by system pressures, and how delivery is now scaling back up. It is explicit about constraints, interdependencies and prioritisation, and sets out the platform from which refreshed plans and trajectories for 2026–2027 are being developed.

2. Programme Overview and Assurance Approach

This report is intended to support Board-level oversight by providing narrative assurance and delivery grip, rather than detailed performance data. It should be read alongside the Urgent and Unscheduled Care Assurance and Performance Report, including SPC charts, which provide the quantitative evidence of performance, variation and signal over time.

The programme is highly interdependent. Progress in one area (such as discharge reliability, Hospital at Home capacity, or frailty pathways) directly impacts performance elsewhere, particularly at the front door. This report therefore focuses on understanding system interactions, sequencing and dependencies, rather than presenting workstreams as standalone initiatives.

3. What We Have Achieved So Far (2025/26)

During 2025/26, the U&UC programme delivered material whole-system improvement, with the Discharge Without Delay (DWD) programme a key driver. This is evidenced by total delayed discharges reducing to a mean of **113** (from a baseline of **141**), a sustained increase in weekly acute discharges from **574** to **597**, and emergency admissions average length of stay improving to a mean of **6.9 days** by end March. Together, these improvements supported better bed availability and flow through sustained winter pressure.

Structural improvements were also delivered, including the opening of a dedicated Frailty Unit in May last year and the implementation of Shifting the Balance of Care in June last year, which saw the closure of Ward A11 and the transfer of resource into community-based provision.

Criteria to Reside (CtR) was a key contributor to safely managing the site through Christmas and New Year. Intensive use during December was associated with an improvement in Emergency Department (ED) 4-hour performance of around **12 percentage points** and a reduction in morning ED crowding (ED occupancy at 8am reduced by around **68 percentage points**), despite stable attendances. The same period was also associated with improvements in discharge delay and long-stay (>14 days) cohorts, with overall hospital occupancy trending back toward the local target level.

While December reflected exceptional conditions (including standing down non-essential activity and additional discharge capacity), the learning has been carried into business as usual: CtR is now embedded through the DWD programme, with daily routines, clearer ownership and improved visibility to sustain safer, more reliable flow.

These achievements are not all detailed within individual workstream sections, but together they represent material progress and have created a more stable platform from which the programme is now moving into its next phase.

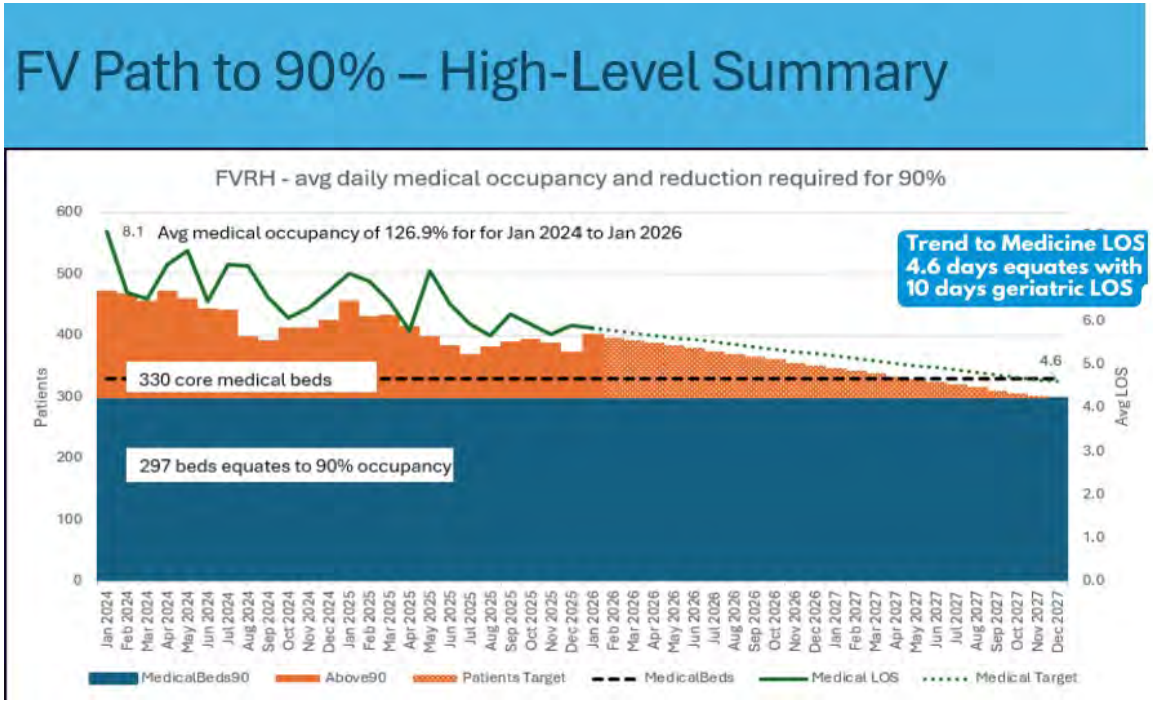


Figure 1: Acute occupancy improvement since 2024

Acute occupancy has improved substantially since 2024 (Figure 1), reflecting stronger system leadership, shared ownership of flow, and a culture of consistent daily routines and follow-through across teams and partners.

4. Current System Position Following Winter Pressure

Winter pressures significantly shaped delivery across the programme. The labour-intensive implementation of Criteria to Reside required a temporary re-prioritisation of U&UC programme capacity to ensure patient safety, slowing progress on some planned improvement activity, particularly at the front door. However, this period also delivered important stabilisation. As Criteria to Reside is embedded into business as usual and system pressure eases, delivery capacity is being released. The programme is now restarting and resequencing work that was paused, with a clearer understanding of constraints, workforce pressures and system dependencies.

March performance snapshot: March data indicates stabilisation following peak winter pressure, although performance remains below required standards. Four-hour Emergency Access Standard compliance was **59.3%** (unchanged from February; improved from **56.9%** in January). ED attendances increased to **5,965** in March, with recent weeks among the highest levels seen this year, reinforcing the picture of sustained high demand. Acute occupancy remains a key constraint with a mean of **107.3%** (improved from a historical mean of 121.2% but above the local target level). Emergency admissions average length of stay is at a mean of **6.9 days**, achieving the ≤7-day target by end March. Total delayed discharges have reduced to a mean of **113** versus a baseline of 141 (≈20% reduction achieved). Within front-door flow, Flow 1 performance improved to **86.9%**, supported in part by continued strong Minor Injury Unit (MIU) utilisation (booked appointments increased from **63.4%** to **67.0%**). Hospital at Home Older Adult utilisation ranged from **68.6%** to **85.7%** during March, with further expansion constrained primarily by recruitment and by the need for consistent senior clinical decision-making and improved digital visibility of capacity.

5. Priority Workstreams – Delivery and Assurance

This section sets out the current delivery position across priority workstreams. For each workstream, the report summarises why the work matters, what it is intended to achieve, the current trajectory and milestones, delivery status, and the evidence used to assure progress.

Workstream content is presented in the tables to provide structure and consistency; narrative commentary is intentionally minimal in this section.

1. Front Door / Emergency Department (ED) Flow Workstream

Why it matters	Intended impact	Performance direction and constraints	Key Milestones / Deliverables
Pressure at the front door is mainly due to **high demand, delays in moving patients on to inpatient beds (exit block), limited physical space, and workforce gaps**—not simply how the ED runs. Some important enabling work is already underway (including CtR, breach analysis and workforce benchmarking). Further improvement now depends on **working with ED teams to agree and introduce practical changes** to triage, streaming and senior clinical decision-making.	Improved patient safety, experience and staff sustainability at the front door; reduced crowding and avoidable waits; more reliable triage and assessment; and a contribution to improved emergency access performance when aligned with system flow.	• The national expectation of a 5% improvement in 4-hour performance by end March 2026 has not been fully realised, reflecting whole-system flow and workforce constraints. • Improvement is expected to be incremental and system-dependent. Early enabling work is underway; further gains rely on co-developed changes to triage, streaming and senior decision-making, aligned with downstream flow and workforce capacity.	• **ED workforce benchmarking reviewed with ED leadership and teams**, translating findings into an agreed **ED workforce plan** (Q1). • Maintain **breach analysis as enabling work**, building understanding of recurrent causes and variation (Q1). • Acknowledge that the original ambition for rapid (12-week) delivery is **no longer realistic** given CtR workload and workforce constraints. • **Undertake structured process mapping with ED teams**, informed by workforce benchmarking, to identify key constraints and priority improvement areas (Q1). • **Develop and agree internal professional standards** for front-door practice and escalation, co-designed with ED teams (Q2). • Agree priority changes to triage, streaming and senior clinical decision-making **for phased implementation**, subject to team agreement • Finalise and progress **ED flow dashboard requirements** to strengthen operational grip (Q3).

Current Delivery Service	Evidence & Measures for Improvement	Key Risks and Mitigations
Red – U&UC capacity has been focused on CtR implementation, which is improving downstream flow but has slowed front-door redesign. ED workforce benchmarking is complete, additional data re patient acuity flow and; engagement and process mapping with ED teams is pending. Breach analysis and professional standards have commenced; communications not yet started. Dashboard requirements are being scoped.	• FV compliance was **59.3%** in March 2026 (unchanged from February and up from **56.9%** in January). This suggests stabilisation after peak winter pressure, although performance remains well below the required standard. • Delays within the ED remain significant: median time to first assessment was 119 minutes, median time to triage 18 minutes, and median time in ED 263 minutes. • 8 and 12-hour breaches remain elevated, indicating ongoing pressure from whole-system flow constraints. • **Breach analysis initiated**, supporting improved understanding of recurrent causes of delay and informing prioritisation of improvement actions	**Risks** • Exit block and high ED occupancy continue to constrain front-door performance and 4-hour improvement. • ED workforce pressures (including senior decision-maker availability) limit pace and sustainability of change. • Digital and data limitations restrict real-time operational grip, breach insight and assurance. • The administrative Flow Navigation Centre model limits real-time diversion, constraining impact on attendances and admissions. **Mitigations** • Develop plan with **ED** • Develop ED workforce plan and phased redesign. • Progress **breach analysis, professional standards and ED dashboards** to strengthen consistency, grip and assurance.

2. Flow Navigation Centre (FNC) Workstream

Why it matters	Intended impact	Performance direction and constraints	Key Milestones / Deliverables
A clinically led FNC enables early senior clinical decision-making (SCDM) at the front door, supporting appropriate routing to urgent care alternatives and reducing avoidable ED attendance and admission. The current administrative model limits real-time influence on flow; transitioning to a SCDM-led model is required to deliver meaningful impact.	• Improved front-door clinical decision-making and pathway navigation. • Reduced avoidable ED attendances and admissions. • Improved utilisation of urgent care alternatives (e.g. MIU, RACU, H@H same-day pathways). • Improved whole-system flow, supporting performance against emergency access standards.	• Progression from the current **administrative** FNC model to an **SCDM-led** model, with phased improvement in routing quality, operational grip and assurance. • **No improvement in attendances or admissions has been evidenced to date**, reflecting the limitations of the current predominantly administrative FNC model. • Reduced ED attendances and admissions would be expected to contribute to improved 4-hour standard.	• Maintain and optimise MIU access and booking model (ongoing), building on existing strong utilisation and scheduled appointment pathways. • Sustain and strengthen Consultant Connect / professional-to-professional pathways (ongoing), supporting navigation to existing urgent care routes including MIU, RACU, H@H and ED where required. • Improve electronic data capture for FNC activity (2026/27 priority), defining a minimum dataset to support routine monitoring of routing decisions, outcomes and utilisation. • Use improved FNC data to support operational grip, assurance and learning, acknowledging that measurement of impact on attendances and admissions is currently constrained by digital limitations. • Progress future FNC model development (including SCDM) in line with regional work and dependencies, with timelines to be confirmed once regional direction is agreed.

Current Delivery Service	Evidence & Measures for Improvement	Key Risks and Mitigations
Amber – the FNC is operational and provides some benefit through navigation to alternative pathways; however, it does not currently operate as an SCDM-led service. Limited electronic data capture restricts operational grip, evaluation of impact and external assurance.	• MIU performance remains strong: booked appointments increased from **63.4%** to **67.0%**, supporting ED flow and 4-hour performance. • **Flow 1 EAS performance was 86.9%** in March, reflecting wider pathway performance and supported in part by strong MIU utilisation. • Prof-to-prof pathways are being used more frequently to support diversion to H@H, MIU and RACU; impact is evidenced directionally. • No demonstrable improvement in ED attendances or admissions is attributable to the current FNC model, reflecting its predominantly administrative design.	**Risks** • Absence of SCDM input limits front-door clinical routing and admission avoidance. • Lack of electronic FNC data constrains operational grip and ability to evidence impact on attendances, admissions and 4-hour performance. **Mitigations** • Phased transition to an SCDM-led FNC, aligned to workforce capacity and regional dependencies. • Prioritise electronic data capture and minimum datasets to strengthen assurance, learning and decision-making. • Leverage existing pathways (MIU booking, Consultant Connect, RACU) to optimise front-door flow while FNC capability matures.

3. Hospital at Home (H@H) Programme

Why it matters	Intended impact	Performance direction and constraints	Key Milestones / Deliverables
Expanding H@H capacity provides a safe alternative to acute admission and enables earlier supported discharge. Impact is maximised where patients are consistently identified and routed at the front door, supported by senior clinical decision-making and clear digital visibility of capacity and activity. Without these enablers, available capacity cannot be optimally utilised or assured.	Reduced acute admissions and improved discharge conversion, contributing to reduced bed occupancy and improved whole-site flow. Indirect improvement to 4-hour performance through reduced ED congestion and improved inpatient flow rather than direct front-door impact.	• H@H is expected to deliver **112 beds by the end of March 2026**, in line with national expectations. (not achieved due to constraints in assuring full H@H+ capacity) • During March, Older Adult H@H utilisation ranged from 68.6% to 85.7%, based on 30 core Older Adult beds, reflecting variable demand and routing (including front door decision-making), rather than unused or excess capacity.	**Progress delivery toward 112 H@H beds by end March 2026,** across core (45 beds) and H@H+ pathways (67 beds). **Core Hospital at Home – Delivered / Assured** • Increase Older Adult capacity from **25 → 30 beds** *(delivered).* • Electronic virtual ward implemented to support **core H@H oversight** *(delivered).* **Core Hospital at Home – Planned / In progress** • Increase OPAT capacity from **2 → 5 beds** *(went live early April)* • **10 Respiratory H@H beds** *(go-live late April)* (2-week ToC December) *(Together forming the planned 45-bed core model once fully operational)* **Hospital at Home+ – Operational but not fully assured** • Key constraint: total H@H+ capacity cannot currently be quantified as bed-equivalents due to the absence of an electronic virtual ward

Current Delivery Service	Evidence & Measures for Improvement	Key Risks and Mitigations
Amber – Partial delivery against plan. Core capacity expanded; however full planned capacity and system impact constrained by workforce recruitment, absence of SCDM-led FNC and lack of electronic virtual ward limiting assurance and optimisation.	• Core H@H capacity is operational and supporting admission avoidance and early discharge, with **utilisation ranging between 68.6% and 85.7% during March**, indicating active use of available capacity rather than unused provision. • Variation in utilisation reflects fluctuating demand, referral suitability and routing, rather than staffing or service availability. • Operational review is now focused on strengthening grip on H@H delivery, including analysis of utilisation by day, staffing cover, referral volumes and reasons for rejection.	**Risks:** • Recruitment timelines delay delivery of full planned H@H capacity. • Limited operational grip on core H@H utilisation (including staffing cover, referral patterns and rejected referrals) constrains optimisation of delivery. • Absence of an electronic virtual ward limits consistent visibility of activity, utilisation and outcomes across H@H and H@H+ pathways. • System-wide routing and senior decision-making dependencies (including FNC) affect utilisation, with **FNC risks and mitigations managed through a separate workstream.** **Mitigations** • Enhanced use of available H@H data to strengthen operational grip. • Accelerate implementation of an electronic virtual ward to improve visibility, utilisation monitoring, operational oversight and external assurance.

4. Whole System Flow & Discharge Programme

Why it matters	Intended impact	Performance direction and constraints	Key Milestones / Deliverables
Whole-system flow depends on early identification of discharge readiness (CtR), effective pathway-based coordination through an Integrated Discharge Service (IDS), visibility of downstream demand via the Community Waiting List, and timely conversion through Discharge to Assess (D2A). The IDS review is critical to enabling a **single point of contact and pathway-based discharge teams**, without which ward-level improvements are protected but whole-system flow gains remain constrained.	SLT-led whole-system alignment of CtR, IDS, Community Waiting List and D2A is essential to improving discharge reliability, reducing delays and improving flow. **Without further progress on these key enablers, particularly pathway-based IDS coordination and D2A, the system will be unable to deliver the additional performance improvement required.**	Performance improvement is expected to be delivered through **aligned whole-system trajectories** rather than isolated targets. Progression across 4-hour performance, occupancy, length of stay and DWD measures is contingent on sustained delivery of the core enablers. As these enablers mature, the system trajectory is toward **improved discharge reliability, reduced exit block and stabilised flow**, enabling sustained improvement across all U&UC KPIs. Without further progress on these enablers, performance improvement will plateau and additional gains will not be achievable.	**CtR embedded as business as usual** across acute wards, with routine use and oversight through existing operational forums (achieved/sustained). **Community Waiting List established as a single system view** of downstream demand, with continued refinement to improve accuracy, categorisation and use for prioritisation (in place; refinement Q1–Q2 2026) **Integrated Discharge Service (IDS) review complete**, agreeing a clear operating model *(Q3 2026).* **Phased transition from interim WBDC to IDS pathway teams**, protecting discharge grip while moving to a sustainable model *(Q3–2026).* **D2A model defined and aligned to pathways**, informed by current system review and community capacity, to support consistent discharge conversion *(model development Q1–Q2 2026; phased implementation thereafter).* **Digital and data enablement progressed** to support system assurance (CtR, discharge status, pathway visibility), recognising this as an enabler rather than a prerequisite *(progressive through 2026).*

Current Delivery Service	Evidence & Measures for Improvement	Key Risks and Mitigations
Amber –Discharge grip has improved through Criteria to Reside and interim ward-level coordination, but further progress depends on completing the IDS review and strengthening pathway-based coordination and Discharge to Assess.	Evidence of sustained improvement is demonstrated through **DWD outcomes summarised in Table 5 below**, including improved discharge reliability, reductions in delays and strengthened grip on long stay cohorts, supported by routine CtR use and system oversight. • Total delayed discharges have reduced to a mean of **113** versus baseline **141** (≈20% reduction achieved).	**Risks:** Without sustained **SLT ownership and whole-system leadership**, the system risks losing momentum, limiting the ability to build on established **DWD** improvements and deliver further performance gain. **Mitigations** Continued **SLT-led oversight** through the Whole System forum to drive alignment, pace and accountability for IDS delivery, pathway coordination and D2A, protecting gains already achieved and enabling the next phase of improvement.

5. National Discharge Without Delay (DWD) Collaborative

Why it matters	Intended impact	Performance direction and constraints	Key Milestones / Deliverables
Embedding DWD principles as business as usual across acute and community settings enables earlier identification of patients who no longer require acute care and improves the reliability of discharge planning. Delivery is dependent on **four inter-linked workstreams**: **Frailty at the Front Door**, to enable early senior decision-making and avoid unnecessary admission; **Planned Dater Discharge (PDD) / Integrated Discharge Service (IDS)**, to provide consistent ward-level coordination, proactive discharge planning and effective escalation; **Community Hospitals / Step-down**, to support onward flow and prevent long lengths of stay; **Discharge to Assess (D2A)**, to convert discharge readiness into timely discharge with appropriate community support.	• Reduced delayed discharges across acute and community hospital settings • Improved reliability and timeliness of discharge • Reduced average length of stay, including long-stay cohorts. • Improved bed availability and flow resilience. • Indirect improvement to emergency access performance through reduced exit block and sustained lower occupancy.	· 95% hospital occupancy, by March 2026 (not achieved; current mean 107.3%, improved from 119.0% baseline). • Acute hospital ALoS of 7.0 days, by March 2026 (achieved; current mean 6.9 days) • 20% reduction in community hospital ALoS, by March 2026 (not acheived10.6% reduction improving from a baseline of 70.7 days to 63.2 days) • 20% reduction in total delayed discharges, by March 2026 (achieved near 20% reduction improving from a baseline of 141 to 113). • 25% reduction in acute delays, by March 2026 (achieved 22% reduction improving from a baseline of 36 to 28).	**Frailty at the Front Door** (see table 6 below) **PDD/IDS** PDD embedded to support proactive discharge planning and timely escalation WBDCs aligned to wards to coordinate actions and resolve discharge barriers Balance scorecards with target number of discharges and ward LoS. **Community Hospitals / Step-down** Strengthened discharge planning, including PDD setting and routine review of long-stay cohorts. **Discharge to Assess** Model in development.

Current Delivery Service	Evidence & Measures for Improvement	Key Risks and Mitigations
Amber – core DWD principles are embedded and delivering sustained improvement; however, further progress and long-term sustainability remain constrained by downstream capacity, variability in access to D2A and step-down capacity, and the need to further stabilise discharge arrangements across community pathways.	• Sustained performance confirmed through multiple consecutive periods below baseline • Control-chart signals and trend stability used to distinguish sustained improvement from short-term variation • Routine operational grip via CtR compliance, PDD accuracy and long-stay (>14 days) cohort review • Community hospital LoS and delay trends reviewed routinely to monitor sustainment and reversal risk	**Risks** Limited availability of D2A, community hospital step-down constrains discharge conversion. Inconsistent PDD quality and weekend discharge reliability reduces confidence in expected discharge timing. Workforce pressures across acute, community and partner services impact MDT cadence and pace of discharge actions. **Mitigations** Protect and strengthen ward-level discharge coordination with clear minimum standards and escalation routes. Embed consistent PDD discipline across acute and community settings, supported by audit and feedback. Improve discharge conversion through earlier referral, proactive matching to D2A and routine system flow huddles.

6. Frailty at the Front Door

Why it matters	Intended impact	Performance direction and constraints	Key Milestones / Deliverables
Early identification of frailty at the front door enables timely Comprehensive Geriatric Assessment (CGA) and senior decision-making, supporting avoidance of unnecessary admission, shorter stays and better discharge planning. Impact is maximised where frailty pathways have reliable access to D2A and stepdown pathways.	Improved outcomes and flow for older people through earlier assessment and correct pathway selection; increased same-day/early discharge; reduced avoidable admission and length of stay; reduced long waits and 4-hour breaches for older people (indirectly via improved flow).	• 100% of patients over the age of 65 screened for frailty within 4 hours of arrival (not electronically recorded). • 95% of patients identified as frail with CGA within 24 hours (achieved). • 50% direct discharge and 4-day ALoS in Acute Frailty Unit (not achieved). • 10% reduction in geriatric LoS, by end December 2025 (not achieved target 12.5 days end Dec 18.6 days).	**7-day service development:** progressive MDT recruitment and workforce modelling to move toward a sustainable 7-day frailty service. **Frailty Unit flow controls:** maintain access SOP and criteria to protect unit function and improve access within 4 hours of acceptance. **Timely screening/CGA:** move from current model toward HIS-aligned targets (screen within 1 hour; CGA within 4 hours). **Frailty screening in ED:** implement frailty screening at the front door to support early identification and prioritisation for frailty pathways. **Frailty screening (digital enablement):** agree TrakCare build + Frailty RAG; SOPs; baseline audit; training; pilot then expand to BAU.

Current Delivery Service	Evidence & Measures for Improvement	Key Risks and Mitigations
Amber - Delivery is mixed: the Acute Frailty Unit is working well with robust MDT huddle and PDD focus; however, achieving discharge conversion (direct discharge) is constrained by limited access to D2A and step-down capacity, resulting in downstream transfers and increased geriatric pathway LoS.	**Frailty screening:** 100% of patients aged 65+ are assessed for frailty on arrival; however, screening is not yet electronically recorded, limiting routine reporting and assurance. **CGA delivery**: 95% of patients identified as frail receive a Comprehensive Geriatric Assessment within 24 hours (achieved). **MDT quality:** HIS described the Frailty Unit MDT huddle as gold-standard, providing strong clinical oversight and proactive discharge planning. **Discharge conversion and LoS**: Further improvement in direct discharge, Frailty Unit ALoS and specialist geriatric length of stay is constrained by exit block, with downstream transfers monitored through routine review of frailty discharge routes and long-stay cohorts.	**Risks** • Frailty screening not electronically captured → limited visibility of frail/non-frail/excluded cohorts and weakened assurance. • Direct discharge target constrained by limited access to D2A and community hospital step-down capacity → onward transfers and increased downstream LoS. **Mitigations** • Implement electronic frailty screening in TrakCare using Frailty RAG, embed in SOP/workflow, and use dashboards/Quality Assurance to strengthen grip. • Strengthen and formalise access to D2A and step-down to improve discharge conversion (direct discharge) from the Frailty Unit.

7. Transition to the Next Phase (2026–2027)

NHS Forth Valley has an established local Urgent and Unscheduled Care improvement plan and has delivered significant progress during 2025/26. We are now entering a transition phase, with a request to develop a refreshed plan that aligns to the Centre for Sustainable Delivery (CfSD) vision for urgent and unscheduled care and its priority areas.

This work will help ensure local delivery is clearly organised against the agreed national direction, strengthen assurance, and support prioritisation and sequencing across interdependent workstreams. A draft aligned plan and updated trajectories for 2026–2027 are being developed, with further detail to follow in subsequent reports.

8. What Happens Next

The programme will continue to scale back up improvement activity as Criteria to Reside is embedded and delivery capacity increases. Future focus will be on prioritising work in the right order, strengthening day-to-day oversight and assurance, and developing a refreshed plan aligned to the CfSD vision and priority areas for urgent and unscheduled care. Subsequent iterations of this report will reflect that evolution.

Next 4 weeks – key actions

- **ED staffing plan:** finalise the ED staffing plan following the workforce benchmarking exercise, including the paper for ELT (in development), to support safe staffing and enable phased front-door improvement.
- **ED improvement actions:** complete the next cycle of breach analysis and structured process mapping with ED teams (triage, streaming and senior decision-making), agreeing a small number of priority actions for testing and phased implementation.
- **Targeted early flow intervention:** introduce a **time-limited, phased implementation** of priority components to create headroom—early identification of next-day discharges, proactive use of the discharge lounge, faster movement once beds are available, and clear ownership of patient flow each shift.
- **Grip and measures:** put in place daily/weekly monitoring of ED occupancy at **08:00**, discharge lounge moves **before midday**, and time from bed allocation to transfer (front door and ED), supported by timely TrakCare updates and escalation where data is not current.
- **Plan refresh:** progress the refreshed urgent and unscheduled care plan aligned to the CfSD vision and priority areas, including sequencing, dependencies and updated trajectories for 2026–2027.

Section 3: Performance Report - Priority Areas of Performance

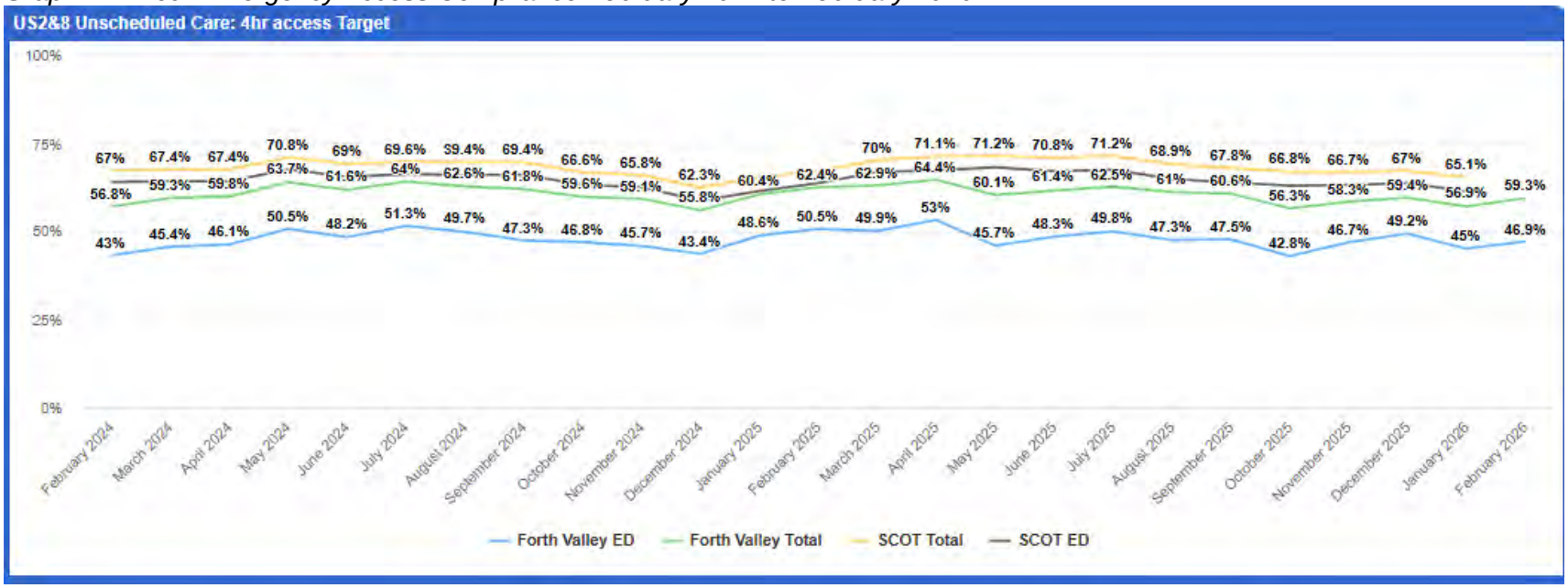
Unscheduled Care

4-hour Access Standard

Percentage of patients waiting less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment - 95% standard.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Emergency Department % compliance against 4 hour access target	28-Feb-26	95%	46.9%	45.0%	50.5%	▼	61.2%	31-Jan-26
Monthly	NHS Forth Valley Overall % compliance against 4 hour target	28-Feb-26	95%	59.3%	56.9%	62.3%	▼	65.1%	31-Jan-26

Graph 2: 4-hour Emergency Access Compliance February 2024 to February 2026

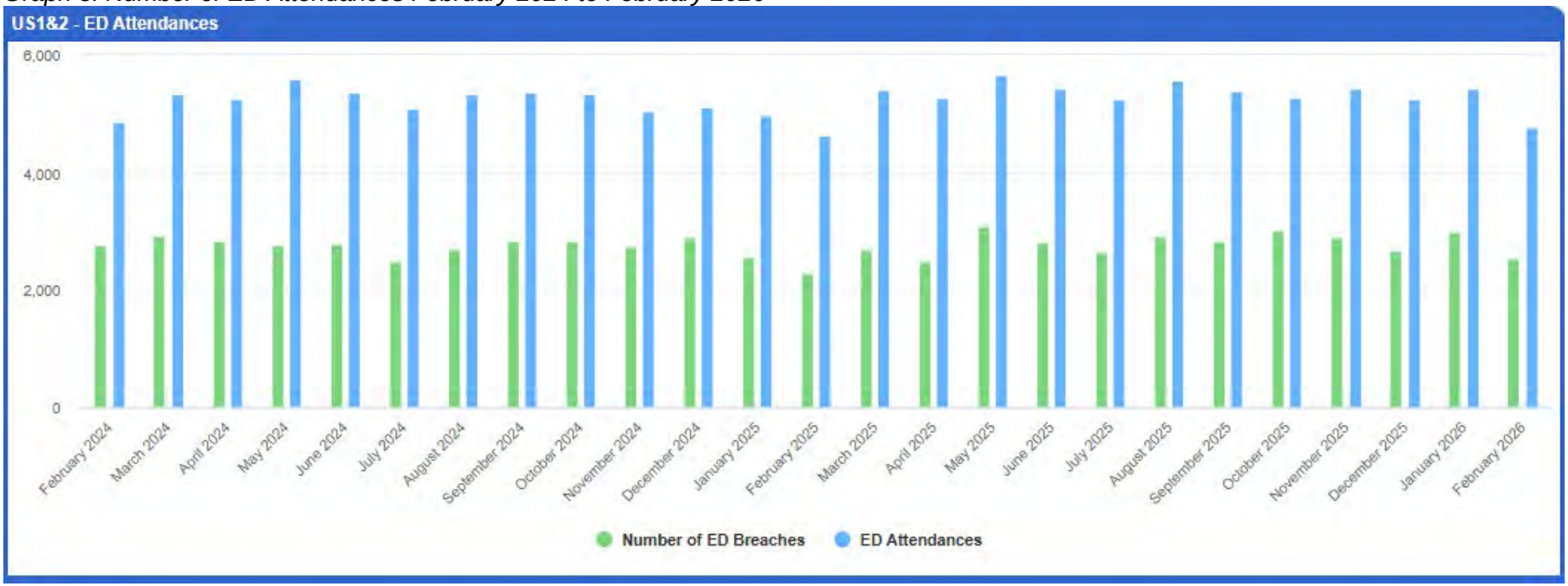


Overall compliance with the 4-hour emergency access standard (EAS) in February 2026 was 59.3%; Minor Injuries Unit 99.5%, Emergency Department 46.9%. A total of 2,527 patients waited longer than the 4-hour target across both the ED and Minor Injuries Unit (MIU); with 1,264 waits longer than eight hours, 582 waits longer than 12 hours and 57 waits longer than 23 hours.

Emergency Department

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total Number of ED Attendances	28-Feb-26	Reduction	4,763	5,424	4,634	▼	-	-
Monthly	Number that waited >4 hours in ED	28-Feb-26	Reduction	2,527	2,985	2,292	▼	-	-

Graph 3: Number of ED Attendances February 2024 to February 2026



The main reason for patients waiting beyond 4 hours continues to be wait for first assessment with a cohort of 1,574 patients, noting this was 1,348 in February 2025. Wait for a bed accounted for 583 patients waiting beyond 4 hours with Clinical reasons accounting for 127 breaches. It is worth noting 744 of patients attending ED in February 2026 did not wait.

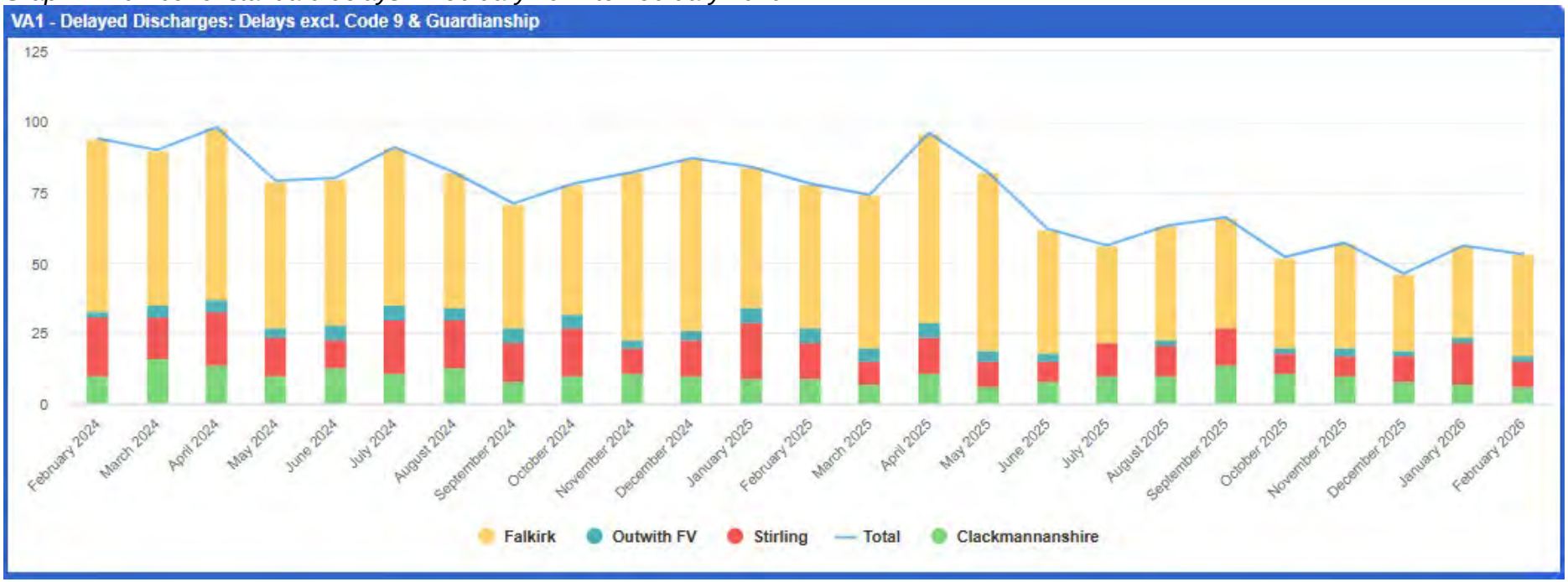
Work continues to support delivery of actions aligned to the various workstreams and projects underway system wide to support ongoing improvements in performance. In addition, NHS Forth Valley has joined the Discharge without Delay Collaborative which will influence the structure of how we align the ongoing actions in, and reporting through, one consolidated Urgent and Unscheduled Care/Delayed Discharge plan.

The Discharge without Delay programme underpins the work already underway in Forth Valley and focusses on four integrated delivery workstreams: Planned Date of Discharge and Integrated Discharge Hubs; Discharge to assess / Home First; Frailty at the Front Door; Community Hospital and Step-Down Rehabilitation Units. The aim is to improve the patient and staff experience, building towards better performance and flow through the hospital. This in turn will reduce patient length of stay and support a reduction in the financial burden.

Delayed Discharge

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Delayed Discharges - excl. Code 9 & Guardianship (Standard Delays)	28-Feb-26	Reduction	53	56	78	▲	-	-
Monthly	Code 9 & Guardianship Delays	28-Feb-26	Reduction	51	59	44	▼	-	-
Monthly	Total Bed Days Occupied by Delayed Discharges (Standard Delays)	28-Feb-26	Reduction	2,146	1,644	2,436	▲	-	-

Graph 4: Number of standard delays – February 2024 to February 2026



The February 2026 census position in relation to standard delays (excluding Code 9 and guardianship) is 53 delays; this is compared to 78 in February 2025.

There was a total of 51 code 9 and guardianship delays, with the total number of delayed discharges noted as 104.

In addition, there were 2 code 100 patients. (These patients are undergoing a change in care setting and should not be classified as delayed discharges however are monitored).

The number of bed days occupied by delayed discharges (excluding code 9 and 100) at the February 2026 census was 2,146, this is a reduction from 2,436 in February 2025. Local authority breakdown is noted as Clackmannanshire 121, Falkirk 1,528, Stirling 474. In addition, there were 23 bed days occupied by delayed discharges for local authorities' out with Forth Valley.

The issue of delayed discharges aligned to urgent & unscheduled care and system flow, is receiving considerable daily focus by the respective HSCP Chief Officers and their teams, jointly with the Acute hospital site, with weekly meetings in place. There is a continued focus on refining processes across our whole system discharge and flow activity. This includes process improvements around assessment and for adults with incapacity. Colleagues are visiting other board areas to learn from what is working well elsewhere and developing tests of change locally.

It should be noted that delayed discharges across Scotland are a particular focus of attention at Scottish Government and COSLA.

Scheduled Care

Outpatients

The percentage of patients waiting less than 12 weeks from referral to a first outpatient appointment – 95% Target.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total Number of New Outpatients Waiting	28-Feb-26	Reduction	18,291	17,599	13,177	▼	-	-
Monthly	Number of New Outpatients waiting over 12 weeks	28-Feb-26	Reduction	7,415	7,023	3,845	▼	-	-
Monthly	Number of New Outpatients waiting over 52 weeks	28-Feb-26	0	113	209	194	▲	-	-
Monthly	New Outpatients waiting under 12 weeks %	28-Feb-26	95%	59.5%	60.1%	70.8%	▼	43.4%	31-Jan-26

Graph 5: Outpatient waits over 12 weeks – February 2024 to February 2026

NHS Forth Valley concurrently treat patients that require urgent clinical care as well as those waiting for long periods, in line with associated Scottish Government guidance and targets.

At the end of February 2026, the number of patients on the waiting list for a first outpatient appointment was 18,291 (17,694 excluding mutual aid) compared with 13,177 in February 2025 with the number waiting beyond 12 weeks 7,415 (7,035 excluding mutual aid) compared to 3,845 in February 2025. Note 59.5% (60.2% excluding mutual aid) of patients were waiting less than 12 weeks for a first appointment; a decline in performance from 70.8% the same period the previous year.

The Scottish Government target for 2025/26 that 0 patients waiting over 52 weeks for a New Outpatient appointment. The graph and table below show the numbers and breakdown by specialty. Most specialties have no waits over 52 weeks and those that do are minimal.

The Scottish Government published updated waiting times guidance on 4 December 2023. The guidance aims to ensure consistency in how waiting lists are managed and to this end includes revisions to the ways in which adjustments can be made in relation to clock pauses and resets.

The 2023 Waiting Times Guidance revisions require changes to local patient management systems and the national waiting times data mart which is managed by Public Health Scotland.

Public Health Scotland data publications are now consistent with the 2023 guidance.

As NHS Forth Valley is progressing with implementation of the 2023 guidance in our patient management system, we are currently still accessing waiting times data based on calculations compliant with previous guidance. Resulting in differences in waiting times data provided from local system by NHS Forth Valley in comparison to data provided by Public Health Scotland in the interim period.

Graph 6: Number waiting over 52 weeks for new outpatient appointment - February 2024 to February 2026

Table 1: Number waiting over 52 weeks for New Outpatient appointment by Specialty – February 2026

Planned Care - New outpatient >52 Week waits

LG Service Area	Value	Numerator	Denominator
Respiratory Medicine	7.0%	46	659
Dermatology	.8%	31	3,754
Urology	1.7%	14	819
General Surgery - Plastics	4.3%	13	305
Paediatrics	.4%	2	453

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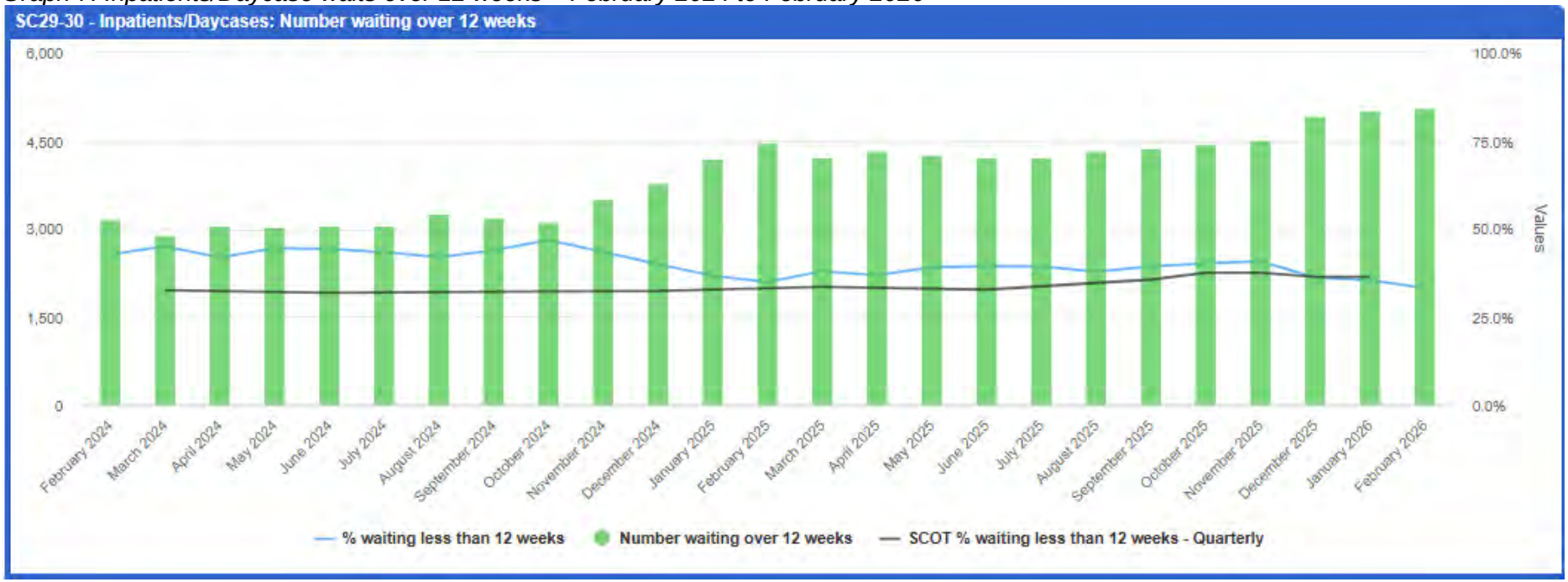
Inpatients

Treatment Time Guarantee (TTG) - Eligible patients who start to receive their day case or inpatient treatment within 12 weeks of the agreement to treat – 100% Target.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Quarterly	Number of patients that waited >12 weeks - Completed Wait	31-Dec-25	0	1,847	2,054	1,386	-	-	-
Quarterly	% Compliance with 12 week TTG Standard	31-Dec-25	100%	35.4%	33.6%	44.6%	▼	58.6%	31-Dec-25
Monthly	Total Number of Inpatients/Day cases Waiting	28-Feb-26	Reduction	7,578	7,782	6,873	▼	-	-
Monthly	Number of Inpatients/Day cases waiting over 12 weeks	28-Feb-26	Reduction	5,062	5,026	4,475	▼	-	-
Monthly	Number of Inpatients/Day cases waiting over 52 weeks	28-Feb-26	0%	265	367	645	▲	-	-
Monthly	Percentage of Inpatients/Day cases waiting under 12 weeks	28-Feb-26	100%	33.2%	35.4%	34.9%	▼	36.3%	31-Dec-25

Graph 7: Inpatients/Daycase waits over 12 weeks – February 2024 to February 2026



In February 2026, the number of inpatients/daycases waiting decreased to 7,578 (7,265 excluding mutual aid and NTC) from 7,782 (7,346 excluding mutual aid and NTC) the previous month. An increase from the previous year in those waiting beyond 12 weeks from 4,475 to 5,062 was also noted.

The aim for 2025/26 is that there will be no patients waiting beyond 52 weeks for Inpatient / Daycase treatment. Graph 16 and table 2 below show the numbers and breakdown by specialty respectively as at end of May. Weekly monitoring of the specialties with the largest numbers waiting over 12 weeks would suggest, based on progress so far, that we are on track to meet the target for end of March 2026. Details are included in the specialty sections below.

Graph 8: Number waiting over 52 weeks for Inpatient/Daycase – February 2024 to February 2026

Table 2: Number waiting over 52 weeks for Inpatient/Daycase by Specialty – February 2026

Planned Care - TTG >52 Week waits

LG Service Area	Value	Numerator	Denominator
Trauma and Orthopaedic Surgery	4.4%	114	2,611
Ear, Nose and Throat (ENT)	8.5%	70	828
Urology	9.3%	39	421
General Surgery	2.7%	21	789
Gynaecology	3.2%	18	566
Vascular Surgery	3.0%	2	67
Ophthalmology	.0%	1	2,045
Pain Management	2.6%	1	38

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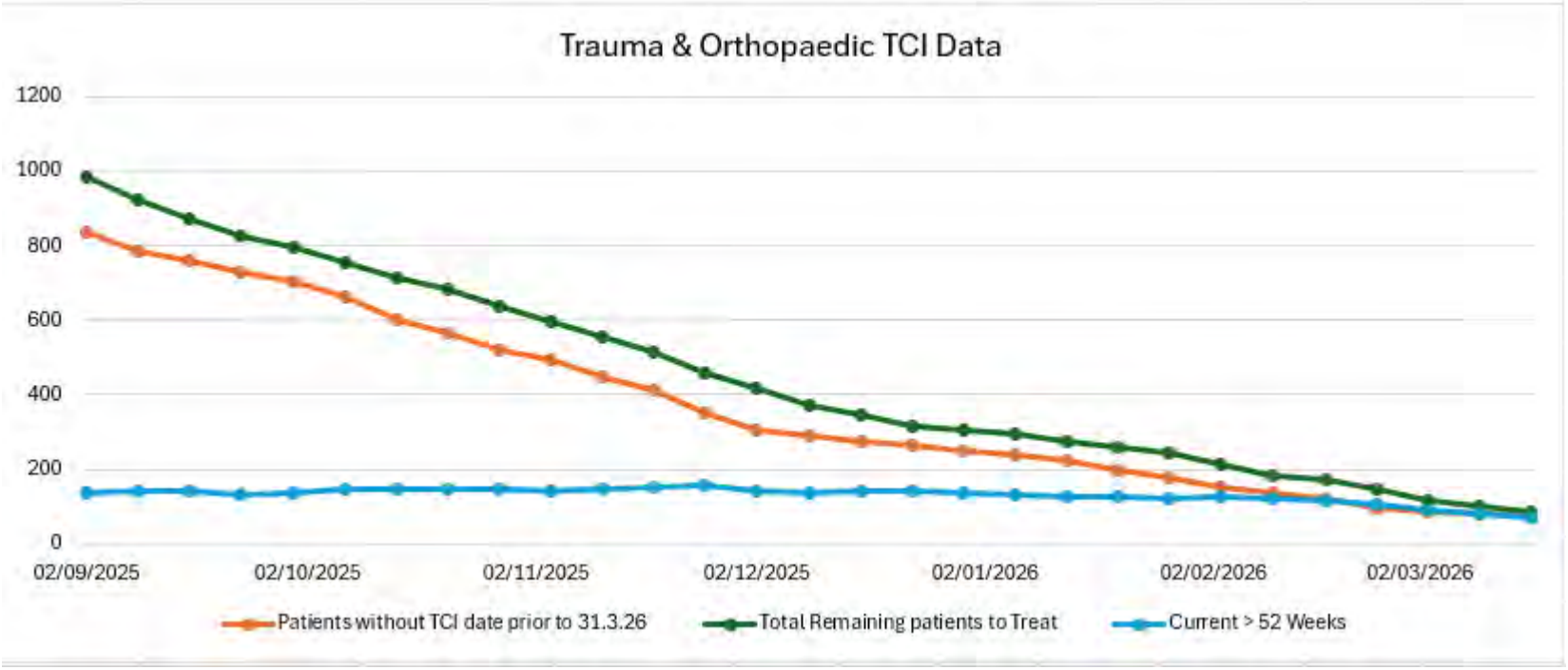
The following specialty level sections detail the weekly position of the waiting lists with the largest numbers waiting over 52 weeks, these show the numbers waiting in total and the numbers dated To Come In (TCI). Further breakdowns show the numbers waiting over 52 weeks and the numbers and percentages of these which are dated to come in and of which are currently unavailable.

Trauma and Orthopaedic Surgery

Table 3: Trauma and Orthopaedic clearance of IPDC >52-week waiters

		Included: Trauma and Orthopaedic Surgery Patients who would be waiting 52 weeks or over at 31st March 2026									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.26	Patients without TCI date prior to 31.3.26	Total Remaining patients to Treat	Current > 52 Weel	Current > 78 Wee	Longest Wait (weel	No > 52 Weeks Datec	No > 52 Weeks Unavailab	% of 52 Weeks Datec	% of 52 Weeks Unavailab
02/09/2025	Trauma and Orthopaedic Surgery	150	834	984	135	8	95	28	24	20	17
09/09/2025	Trauma and Orthopaedic Surgery	138	785	923	141	8	96	39	27	27	19
16/09/2025	Trauma and Orthopaedic Surgery	113	758	871	140	7	85	33	21	23	15
23/09/2025	Trauma and Orthopaedic Surgery	101	727	828	133	7	96	27	19	20	14
30/09/2025	Trauma and Orthopaedic Surgery	95	702	797	139	9	87	29	19	20	13
07/10/2025	Trauma and Orthopaedic Surgery	94	662	756	146	7	88	27	18	18	12
14/10/2025	Trauma and Orthopaedic Surgery	111	603	714	149	6	89	31	24	20	16
21/10/2025	Trauma and Orthopaedic Surgery	117	564	681	146	6	89	28	27	19	18
28/10/2025	Trauma and Orthopaedic Surgery	115	521	636	147	7	90	34	21	23	14
04/11/2025	Trauma and Orthopaedic Surgery	101	493	594	143	5	89	35	19	24	13
11/11/2025	Trauma and Orthopaedic Surgery	106	448	554	149	4	90	45	23	30	15
18/11/2025	Trauma and Orthopaedic Surgery	98	415	513	153	2	91	45	22	29	14
25/11/2025	Trauma and Orthopaedic Surgery	109	350	459	156	3	92	51	26	32	16
02/12/2025	Trauma and Orthopaedic Surgery	112	307	419	143	2	79	48	27	33	18
09/12/2025	Trauma and Orthopaedic Surgery	83	290	373	135	1	80	35	28	25	20
16/12/2025	Trauma and Orthopaedic Surgery	70	275	345	142	2	82	29	29	20	20
23/12/2025	Trauma and Orthopaedic Surgery	53	265	318	143	1	83	26	33	18	23
30/12/2025	Trauma and Orthopaedic Surgery	58	250	308	137	1	84	30	28	21	20
06/01/2026	Trauma and Orthopaedic Surgery	59	238	297	132	0	77	30	20	22	15
13/01/2026	Trauma and Orthopaedic Surgery	55	222	277	128	1	78	31	18	24	14
20/01/2026	Trauma and Orthopaedic Surgery	62	200	262	125	1	79	34	20	27	16
27/01/2026	Trauma and Orthopaedic Surgery	64	178	242	124	1	80	33	24	26	19
03/02/2026	Trauma and Orthopaedic Surgery	60	154	214	126	1	81	39	23	30	18
10/02/2026	Trauma and Orthopaedic Surgery	46	139	185	121	2	374	39	25	32	20
17/02/2026	Trauma and Orthopaedic Surgery	49	122	171	115	3	79	40	25	34	21
24/02/2026	Trauma and Orthopaedic Surgery	47	98	145	106	3	80	40	26	37	24
03/03/2026	Trauma and Orthopaedic Surgery	31	87	118	92	4	81	26	25	28	27
10/03/2026	Trauma and Orthopaedic Surgery	21	80	101	82	5	93	20	23	24	28
17/03/2026	Trauma and Orthopaedic Surgery	11	74	85	72	4	82	11	24	15	33

Graph 9: Trauma and Orthopaedic reduction of the target cohort

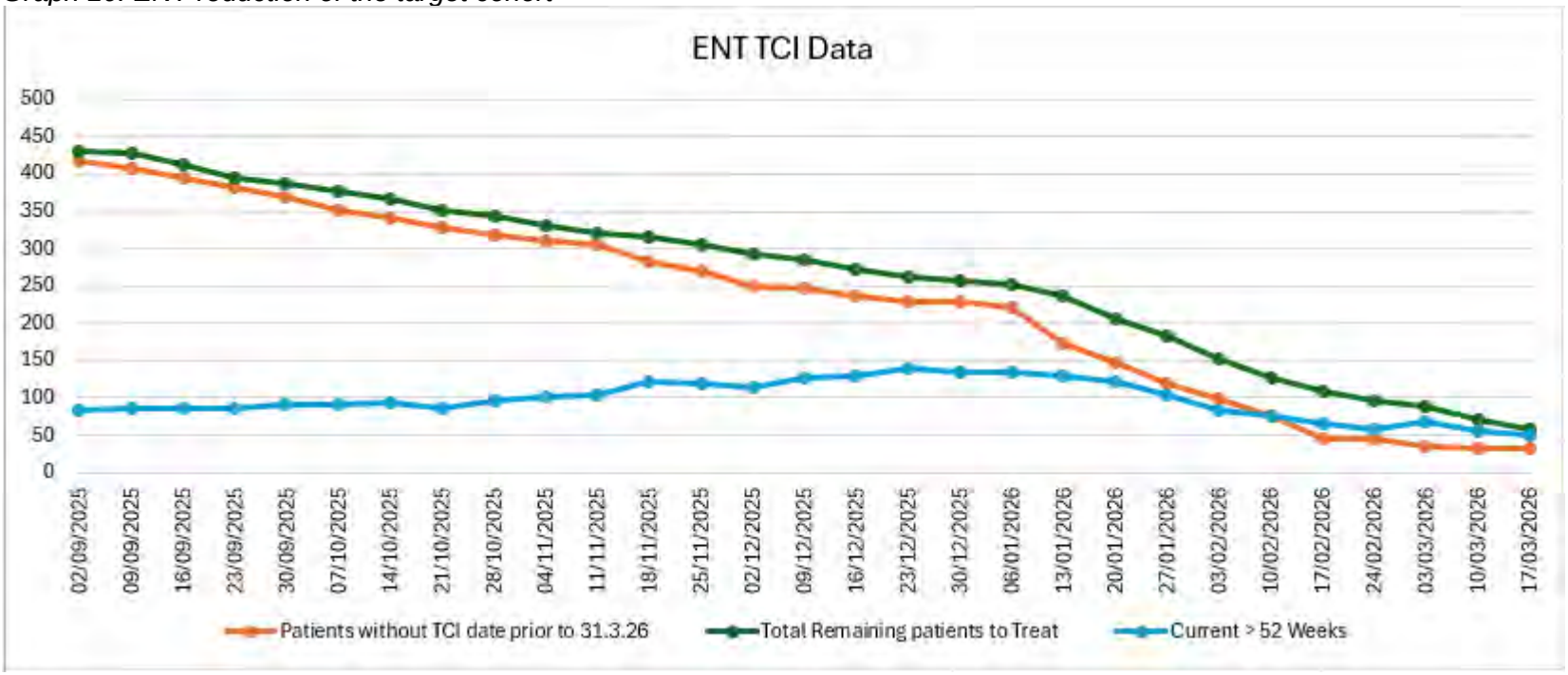


Ear, Nose and Throat

Table 4: ENT clearance of IPDC >52-week waiters

		Included: ENT Patients who would be waiting 52 weeks or over at 31st March 2026									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.26	Patients without TCI date prior to 31.3.26	Total Remaining patients to Treat	Current > 52 Week	Current > 78 Week	Longest Wait (week	No > 52 Weeks Date	No > 52 Weeks Unavailab	% of 52 Weeks Dated	% of 52 Weeks Unavailabl
02/09/2025	Ear, Nose and Throat (ENT)	14	417	431	83	13	94	8	5	9	6
09/09/2025	Ear, Nose and Throat (ENT)	20	408	428	86	13	95	12	7	13	8
16/09/2025	Ear, Nose and Throat (ENT)	19	394	413	86	12	96	9	8	10	9
23/09/2025	Ear, Nose and Throat (ENT)	14	382	396	87	10	97	7	10	8	11
30/09/2025	Ear, Nose and Throat (ENT)	17	369	386	91	10	98	10	10	10	10
07/10/2025	Ear, Nose and Throat (ENT)	25	351	376	90	11	96	16	8	17	8
14/10/2025	Ear, Nose and Throat (ENT)	25	342	367	94	9	94	12	11	12	11
21/10/2025	Ear, Nose and Throat (ENT)	24	328	352	86	5	95	13	11	15	12
28/10/2025	Ear, Nose and Throat (ENT)	25	319	344	96	8	96	17	13	17	13
04/11/2025	Ear, Nose and Throat (ENT)	19	311	330	100	6	97	12	10	12	10
11/11/2025	Ear, Nose and Throat (ENT)	17	305	322	105	6	98	8	12	7	11
18/11/2025	Ear, Nose and Throat (ENT)	33	282	315	121	7	99	27	12	22	9
25/11/2025	Ear, Nose and Throat (ENT)	36	269	305	119	6	100	31	10	26	8
02/12/2025	Ear, Nose and Throat (ENT)	43	250	293	115	7	101	36	9	31	7
09/12/2025	Ear, Nose and Throat (ENT)	39	247	286	128	6	102	34	10	26	7
16/12/2025	Ear, Nose and Throat (ENT)	37	236	273	130	6	103	33	11	25	8
23/12/2025	Ear, Nose and Throat (ENT)	32	230	262	139	6	104	32	12	23	8
30/12/2025	Ear, Nose and Throat (ENT)	29	228	257	134	6	105	27	9	20	6
06/01/2026	Ear, Nose and Throat (ENT)	31	221	252	134	7	106	30	7	22	5
13/01/2026	Ear, Nose and Throat (ENT)	62	174	236	129	5	102	60	5	46	3
20/01/2026	Ear, Nose and Throat (ENT)	59	148	207	121	4	102	54	6	44	4
27/01/2026	Ear, Nose and Throat (ENT)	64	120	184	105	2	95	51	9	48	8
03/02/2026	Ear, Nose and Throat (ENT)	53	99	152	84	0	75	41	11	48	13
10/02/2026	Ear, Nose and Throat (ENT)	51	77	128	77	0	75	37	10	48	12
17/02/2026	Ear, Nose and Throat (ENT)	64	46	110	66	0	76	46	11	69	16
24/02/2026	Ear, Nose and Throat (ENT)	50	45	95	59	0	74	35	11	59	18
03/03/2026	Ear, Nose and Throat (ENT)	55	34	89	67	19	138	46	9	68	13
10/03/2026	Ear, Nose and Throat (ENT)	39	32	71	56	15	139	35	9	62	16
17/03/2026	Ear, Nose and Throat (ENT)	26	33	59	49	10	140	24	12	48	24

Graph 10: ENT reduction of the target cohort

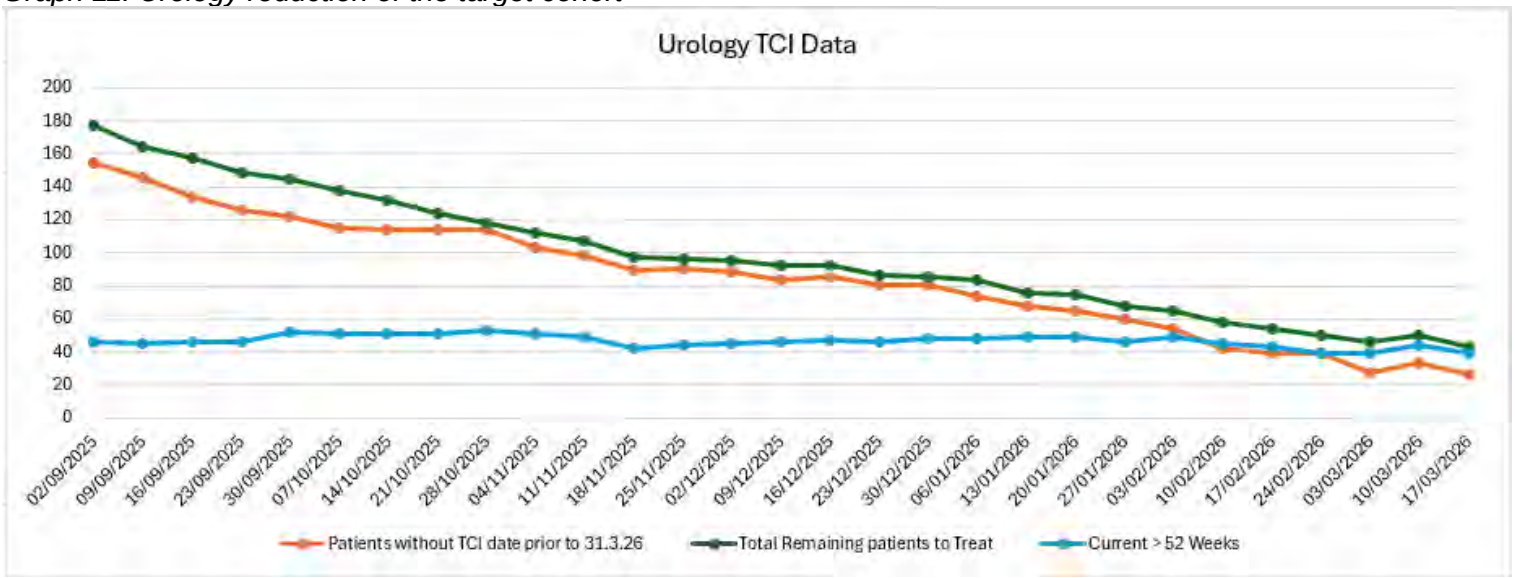


Urology

Table 5: Urology clearance of IPDC >52-week waiters

		Included: Urology Patients who would be waiting 52 weeks or over at 31st March 2026									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.26	Patients without TCI date prior to 31.3.26	Total Remaining patients to Treat	Current > 52 Wee	Current > 78 Wee	Longest Wait (week	No > 52 Weeks Dated	No > 52 Weeks Unavailab	% of 52 Weeks Dated	% of 52 Weeks Unavailab
02/09/2025	Urology	23	154	177	46	17	118	6	4	13	8
09/09/2025	Urology	18	146	164	45	16	119	8	4	17	8
16/09/2025	Urology	23	134	157	46	16	120	8	1	17	2
23/09/2025	Urology	23	126	149	46	12	121	11	0	23	0
30/09/2025	Urology	23	122	145	52	12	122	13	1	25	1
07/10/2025	Urology	23	115	138	51	12	123	10	1	19	1
14/10/2025	Urology	18	114	132	51	12	124	8	2	15	3
21/10/2025	Urology	10	114	124	51	7	125	2	3	3	5
28/10/2025	Urology	4	114	118	53	5	122	1	4	1	7
04/11/2025	Urology	9	103	112	51	4	123	8	4	15	7
11/11/2025	Urology	9	98	107	49	3	87	7	2	14	4
18/11/2025	Urology	8	89	97	42	2	88	2	3	4	7
25/11/2025	Urology	6	90	96	44	2	89	0	4	0	9
02/12/2025	Urology	7	88	95	45	3	90	1	4	2	8
09/12/2025	Urology	8	84	92	46	2	82	3	3	6	6
16/12/2025	Urology	7	85	92	47	2	83	3	4	6	8
23/12/2025	Urology	5	81	86	46	1	84	5	3	10	6
30/12/2025	Urology	4	81	85	48	2	85	4	3	8	6
06/01/2026	Urology	10	74	84	48	1	86	10	2	20	4
13/01/2026	Urology	8	68	76	49	0	75	7	1	14	2
20/01/2026	Urology	10	65	75	49	0	76	9	1	18	2
27/01/2026	Urology	8	60	68	46	0	77	7	1	15	2
03/02/2026	Urology	11	54	65	49	1	78	10	4	20	8
10/02/2026	Urology	16	42	58	45	2	79	14	5	31	11
17/02/2026	Urology	15	39	54	43	2	80	14	6	32	13
24/02/2026	Urology	11	39	50	39	2	81	10	6	25	15
03/03/2026	Urology	19	27	46	39	2	81	18	6	46	15
10/03/2026	Urology	17	33	50	44	2	108	16	6	36	13
17/03/2026	Urology	17	26	43	39	1	109	17	7	43	17

Graph 11: Urology reduction of the target cohort

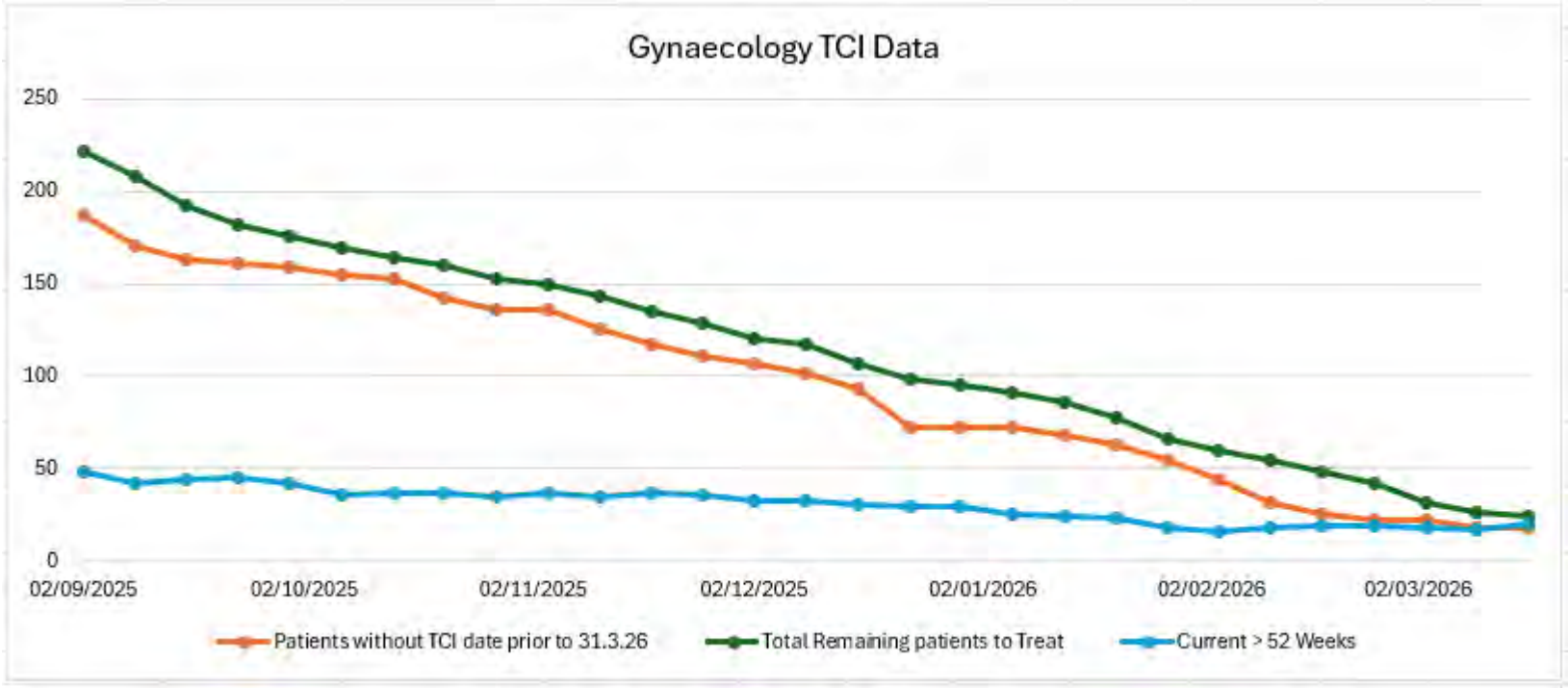


Gynaecology

Table 6: Gynaecology clearance of IPDC >52-week waiters

		Included: Gynaecology Patients who would be waiting 52 weeks or over at 31st March 2026									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.26	Patients without TCI date prior to 31.3.26	Total Remaining patients to Treat	Current > 52 Week	Current > 78 Week	Longest Wait (week	No > 52 Weeks Dated	No > 52 Weeks Unavailal	% of 52 Weeks Date	% of 52 Weeks Unavailal
02/09/2025	Gynaecology	35	187	222	48	5	97	10	5	20	10
09/09/2025	Gynaecology	38	170	208	42	5	98	11	6	26	14
16/09/2025	Gynaecology	29	163	192	44	5	99	11	7	25	15
23/09/2025	Gynaecology	21	161	182	45	5	100	10	4	22	8
30/09/2025	Gynaecology	17	159	176	42	5	101	8	4	19	9
07/10/2025	Gynaecology	14	155	169	36	4	102	5	3	13	8
14/10/2025	Gynaecology	11	153	164	37	4	103	3	2	8	5
21/10/2025	Gynaecology	18	142	160	37	4	104	5	2	13	5
28/10/2025	Gynaecology	17	136	153	35	5	105	4	3	11	8
04/11/2025	Gynaecology	14	136	150	37	6	106	4	4	10	10
11/11/2025	Gynaecology	17	126	143	35	3	107	7	4	20	11
18/11/2025	Gynaecology	18	117	135	37	3	108	12	3	32	8
25/11/2025	Gynaecology	18	111	129	36	4	91	14	3	38	8
02/12/2025	Gynaecology	13	107	120	33	4	92	8	2	24	6
09/12/2025	Gynaecology	16	101	117	33	4	93	12	4	36	12
16/12/2025	Gynaecology	14	93	107	30	3	94	7	5	23	16
23/12/2025	Gynaecology	26	72	98	29	3	95	15	6	51	20
30/12/2025	Gynaecology	23	72	95	29	3	96	16	6	55	20
06/01/2026	Gynaecology	19	72	91	25	2	97	12	3	48	12
13/01/2026	Gynaecology	18	68	86	24	2	98	12	3	50	12
20/01/2026	Gynaecology	14	63	77	23	2	99	10	3	43	13
27/01/2026	Gynaecology	11	55	66	18	2	100	5	3	27	16
03/02/2026	Gynaecology	16	44	60	16	1	101	6	1	37	6
10/02/2026	Gynaecology	23	32	55	18	1	102	6	3	33	16
17/02/2026	Gynaecology	23	25	48	19	1	103	7	4	36	21
24/02/2026	Gynaecology	20	22	42	19	2	104	5	4	26	21
03/03/2026	Gynaecology	9	22	31	18	2	105	2	5	11	27
10/03/2026	Gynaecology	8	18	26	17	2	106	4	5	23	29
17/03/2026	Gynaecology	6	18	24	20	2	107	6	6	30	30

Graph 12: Gynaecology reduction of the target cohort

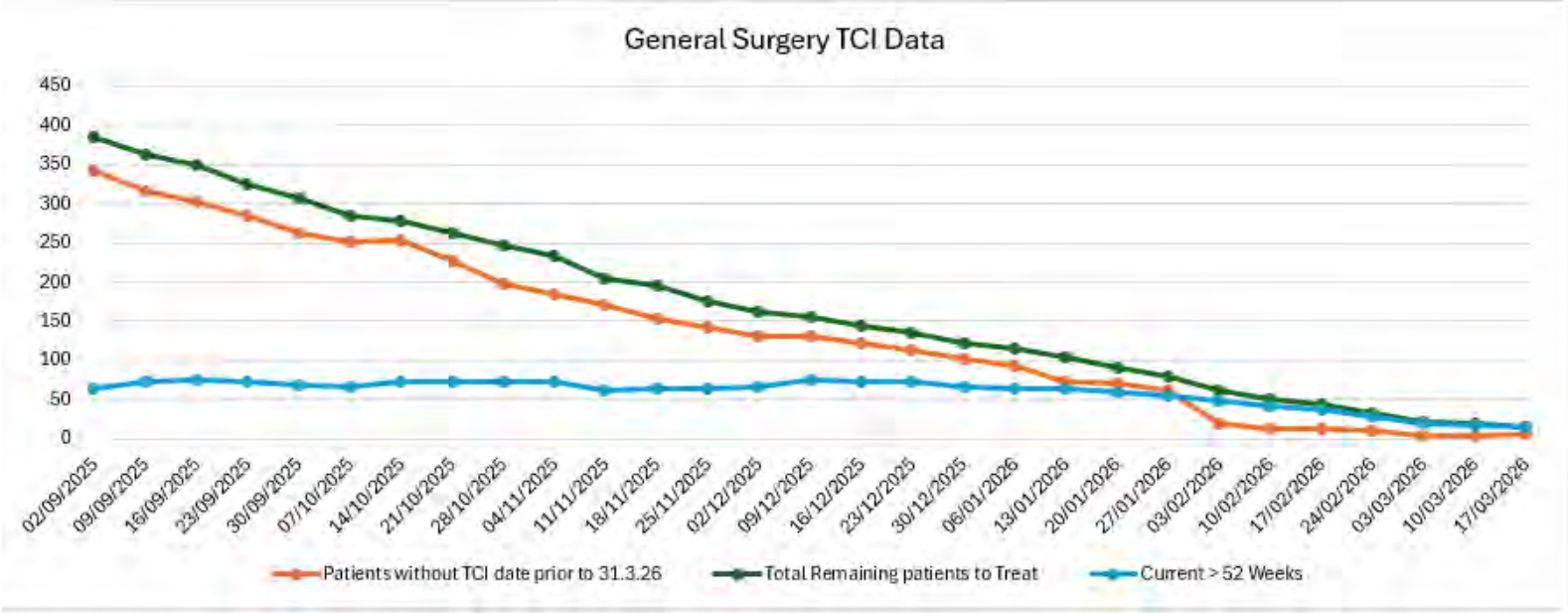


General Surgery

Table 7: General Surgery clearance of IPDC >52-week waiters

		Included: General Surgery Patients who would be waiting 52 weeks or over at 31st March 2026									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.26	Patients without TCI date prior to 31.3.26	Total Remaining patients to Treat	Current > 52 Weel	Current > 78 Wee	Longest Wait (weeks	No > 52 Weeks Date	No > 52 Weeks Unavailab	% of 52 Weeks Dated	% of 52 Weeks Unavailab
02/09/2025	General Surgery	41	343	384	63	7	99	7	8	11	12
09/09/2025	General Surgery	47	316	363	74	8	100	10	9	13	12
16/09/2025	General Surgery	47	302	349	75	9	101	14	9	18	12
23/09/2025	General Surgery	40	285	325	72	8	102	12	9	16	12
30/09/2025	General Surgery	46	262	308	69	6	91	12	9	17	13
07/10/2025	General Surgery	34	251	285	66	5	92	4	10	6	15
14/10/2025	General Surgery	24	253	277	74	6	93	5	12	6	16
21/10/2025	General Surgery	35	227	262	74	5	94	11	9	14	12
28/10/2025	General Surgery	49	198	247	73	6	95	27	7	36	9
04/11/2025	General Surgery	49	185	234	72	5	96	22	11	30	15
11/11/2025	General Surgery	35	170	205	62	3	97	14	8	22	12
18/11/2025	General Surgery	42	153	195	63	2	98	20	10	31	15
25/11/2025	General Surgery	33	143	176	63	1	99	17	9	26	14
02/12/2025	General Surgery	30	132	162	67	1	100	14	12	20	17
09/12/2025	General Surgery	24	131	155	75	1	101	14	17	18	22
16/12/2025	General Surgery	24	121	145	74	2	102	15	17	20	22
23/12/2025	General Surgery	23	112	135	73	2	103	15	17	20	23
30/12/2025	General Surgery	20	102	122	67	4	104	7	16	10	23
06/01/2026	General Surgery	22	93	115	65	4	105	7	14	10	21
13/01/2026	General Surgery	32	73	105	63	5	106	14	17	22	26
20/01/2026	General Surgery	19	71	90	59	3	83	7	18	11	30
27/01/2026	General Surgery	17	62	79	55	3	84	9	19	16	34
03/02/2026	General Surgery	42	20	62	48	3	83	31	16	64	33
10/02/2026	General Surgery	39	12	51	42	4	84	31	10	73	23
17/02/2026	General Surgery	32	13	45	37	5	85	26	8	70	21
24/02/2026	General Surgery	21	11	32	29	3	86	19	9	65	31
03/03/2026	General Surgery	17	5	22	19	1	87	15	5	78	26
10/03/2026	General Surgery	15	5	20	18	1	88	14	4	77	22
17/03/2026	General Surgery	8	6	14	14	0	69	8	4	57	28

Graph 13: General Surgery reduction of the target cohort



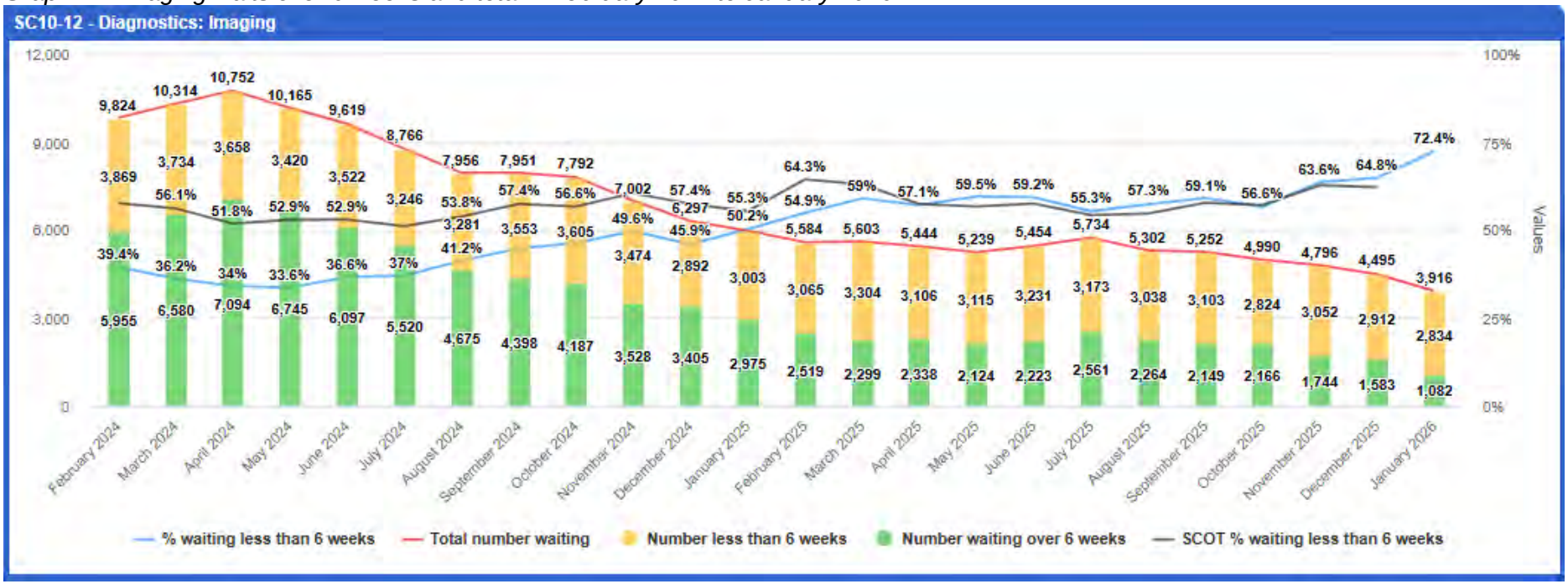
Diagnostics

The Diagnostic Waiting Times Standard states patients should be waiting no more than six weeks for one of the eight key diagnostic tests and investigations.

Imaging

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total number waiting - Imaging	31-Jan-26	Reduction	3,916	4,495	5,978	▲	-	-
Monthly	Number waiting beyond 42 days - Imaging	31-Jan-26	0%	1,082	1,583	2,975	▲	-	-
Monthly	Percentage waiting less than 42 days - Imaging	31-Jan-26	100%	72.4%	64.8%	50.2%	▲	62.1%	31-Dec-25

Graph 14: Imaging waits over 6 weeks and total – February 2024 to January 2026



At the end of January 2026, 1,082 patients were waiting beyond the 6-week standard for imaging, a reduction from 2,975 in January 2025. Compliance with the 6 weeks standard was 72.4%.

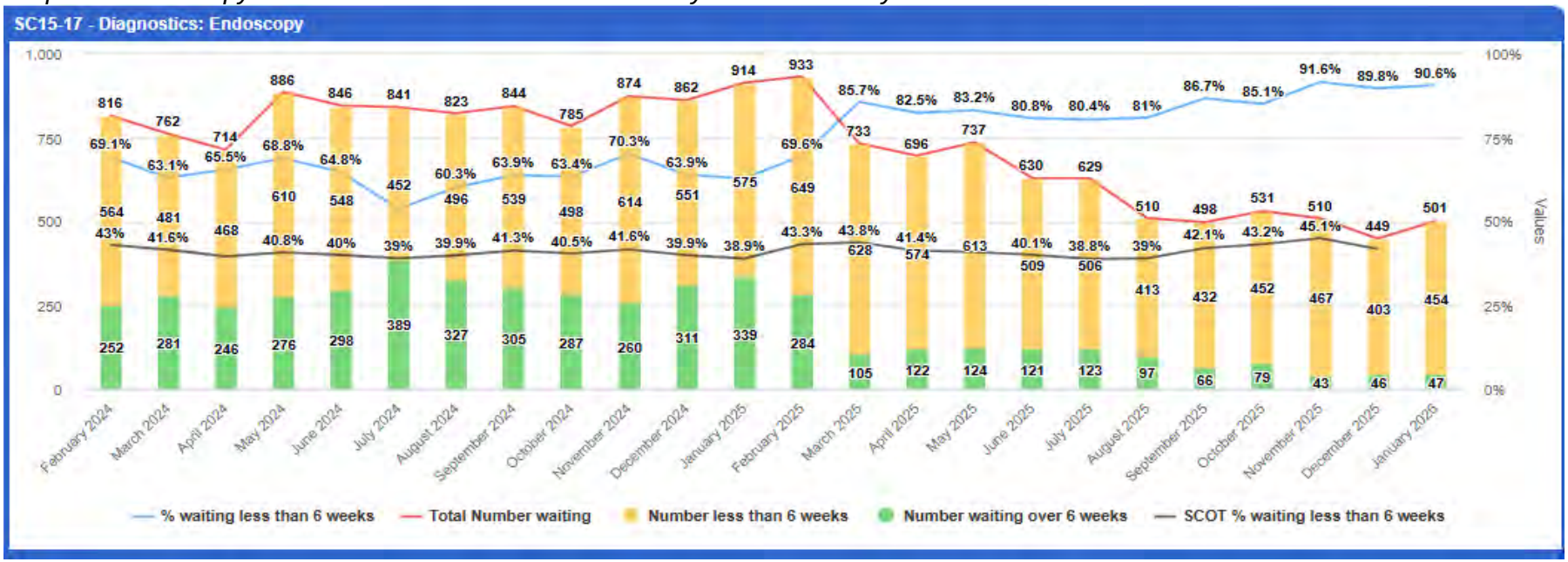
Patients continue to be seen on a priority basis with waiting lists actively monitored and managed on an ongoing basis. The total number of patients waiting for imaging in January 2026 was 3,916; compared with 5,978 in January 2025.

Endoscopy

Waiting times standard is that patients should be waiting no more than six weeks for one of the eight key diagnostic tests and investigations.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total number waiting - Endoscopy	31-Jan-26	Reduction	501	449	914	▲	-	-
Monthly	Number waiting beyond 42 days - Endoscopy	31-Jan-26	0	47	46	339	▲	-	-
Monthly	Percentage waiting less than 42 days - Endoscopy	31-Jan-26	100%	90.6%	89.8%	62.9%	▲	41.8%	31-Dec-25

Graph 15: Endoscopy waits over 6 weeks and total - February 2024 to January 2026



The current waiting list size for endoscopy in January 2026 is 501, compared to 914 in January 2025. NHS Forth Valley Endoscopy team is moving towards achieving the 6-week diagnostic standard. The size of the waiting list continues to reduce and the number of patients waiting over 6 weeks is also reducing. Performance has continued to be over 80% of patients accessing endoscopy within 6 weeks. January 2026 compliance was 90.6% compared with 62.9 in January 2025.

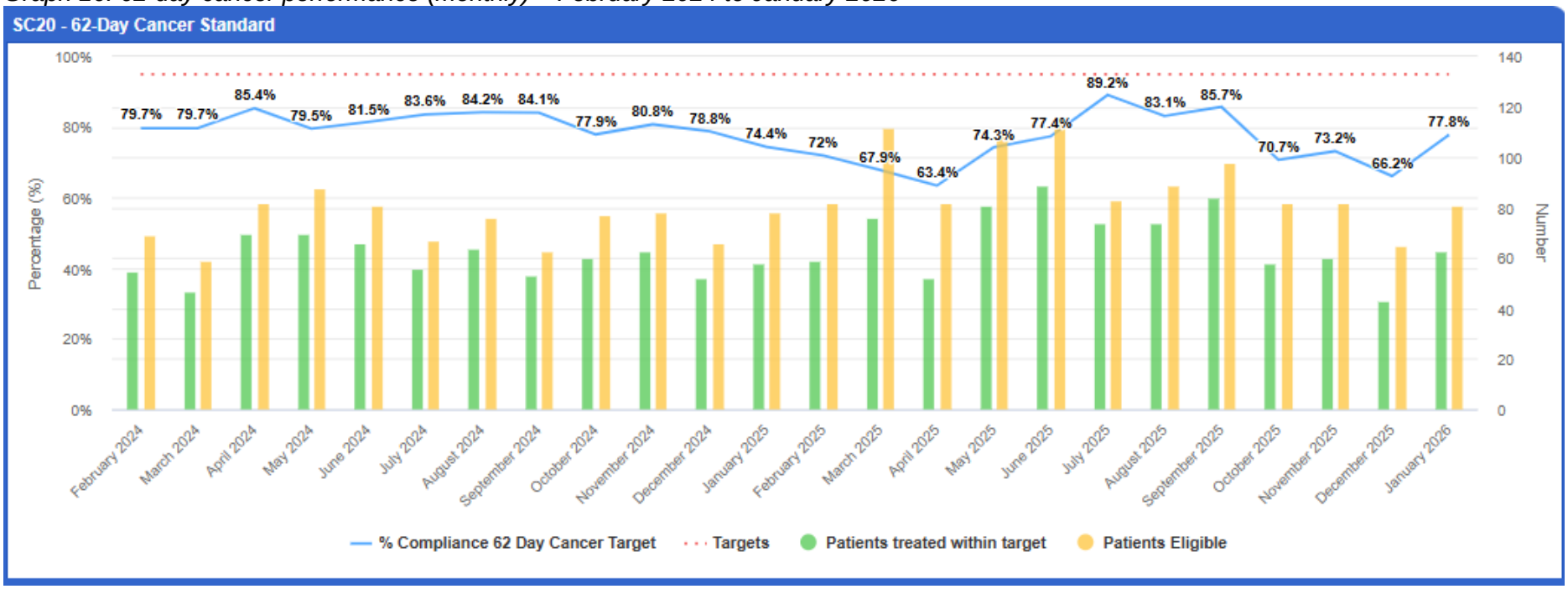
Based on the last published figures the NHS Scotland average performance for Endoscopy is 41.8% of patients were waiting less than the 6 week standard.

62-day Cancer Standard

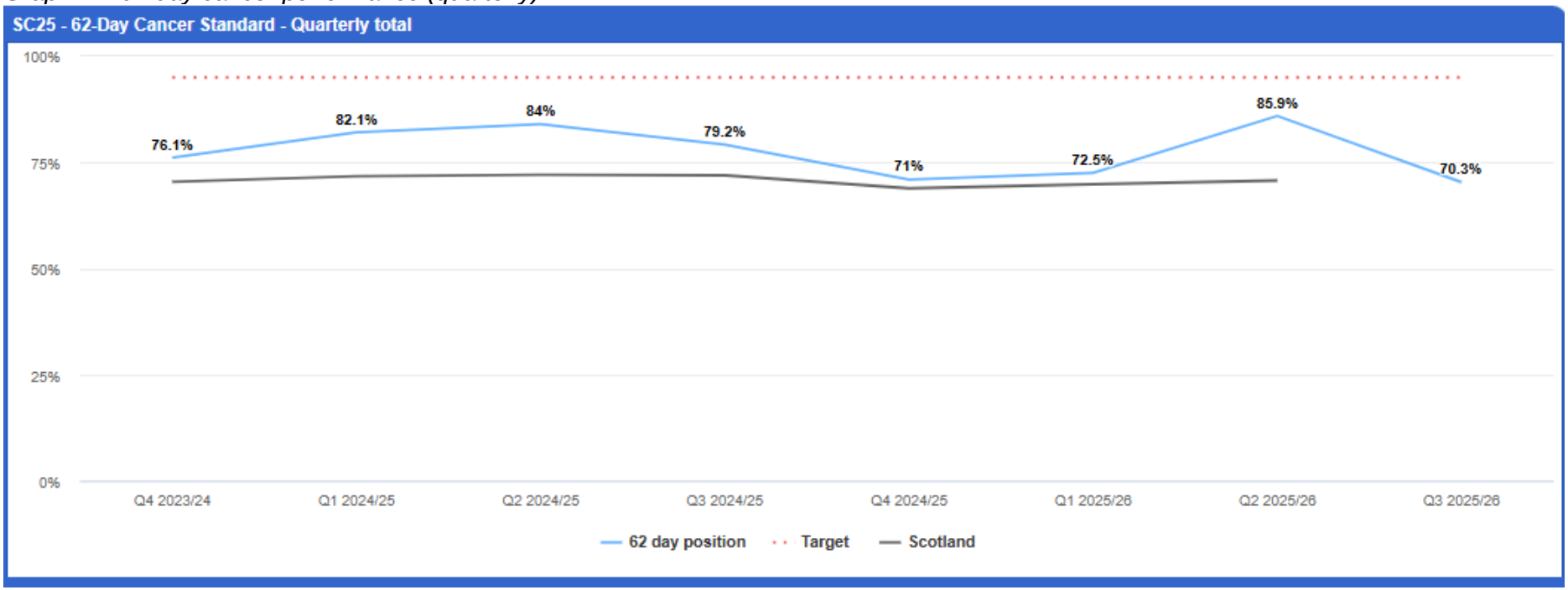
The 62-day standard states that 95% of eligible patients should wait no longer than 62 days from urgent suspicion of cancer referral to first cancer treatment.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	62 Day Cancer Target - Percentage compliance against target	31-Jan-26	95%	77.8%	66.2%	74.4%	▲	69.9%	31-Jan-26
Monthly	62 Day Cancer - Number seen within target against total	31-Jan-26	-	63/81	43/65	58/78	-	-	-
Quarterly	62 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	70.3%	85.9%	79.2%	▼	71.7%	31-Dec-25

Graph 16: 62-day cancer performance (monthly) – February 2024 to January 2026



Graph 17: 62-day cancer performance (quarterly)



Cancer services remain a priority for scheduled care. All Urgent Suspicion of Cancer referrals are tracked to support achievement of the 31-day and 62-day access targets. In areas where this is not reached priority measures are taken to address this. A robust monitoring system has been established to identify reasons for breaches and ensure a plan is in place to prevent further non-compliance where possible. Currently challenges remain in achieving the 95% target in urology with plans in place to address this on ongoing basis along with our tertiary service providers.

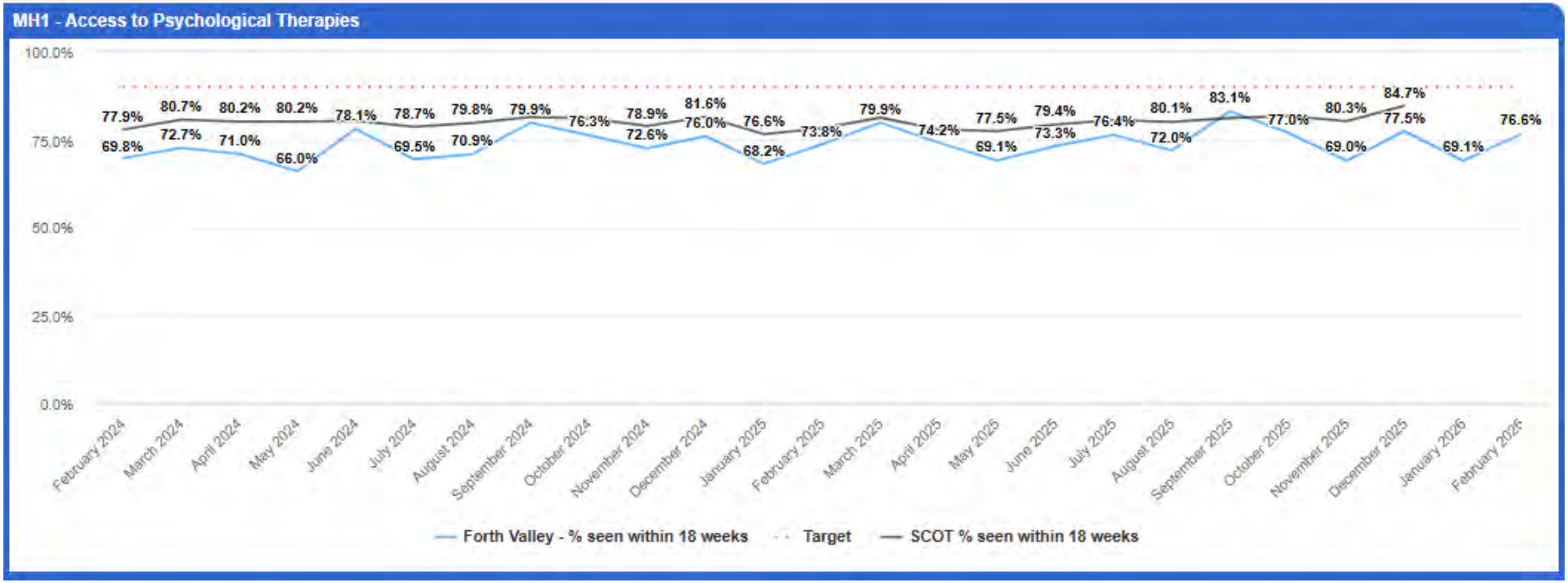
The number of patients being tracked on the 62-day cancer pathway is currently approximately 865 of which 15% are confirmed cancer patients.

Psychological Therapies

The national target is that 90% of patients should wait no longer than 18 weeks from referral to treatment for psychological therapies.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Psychological Therapies - 18 week RTT compliance	28-Feb-26	90%	76.6%	69.1%	73.8%	▲	84.7%	31-Dec-25
Monthly	Total Number Waiting for Pyschological Therapies Initial Assessment	28-Feb-26	Reduction	1,053	956	985	▼	-	-
Quarterly	Psychological Therapies - 18 week RTT compliance	31-Dec-25	90%	74.1%	77.1%	74.8%	▼	82.1%	31-Dec-25

Graph 18: Psychological Therapies 18-week RTT – February 2024 to February 2026


MH1 - Access to Psychological Therapies
100.0%
75.0%
50.0%
25.0%
0.0%
77.9% 80.7% 80.2% 80.2% 78.1% 78.7% 79.8% 79.9% 76.3% 78.9% 81.6% 76.6% 73.8% 79.9% 74.2% 77.5% 79.4% 76.4% 80.1% 83.1% 77.0% 80.3% 84.7% 76.6%
69.8% 72.7% 71.0% 66.0% 69.5% 70.9% 72.6% 76.0% 68.2% 69.1% 73.3% 72.0% 69.0% 77.5% 69.1%
February 2024 March 2024 April 2024 May 2024 June 2024 July 2024 August 2024 September 2024 October 2024 November 2024 December 2024 January 2025 February 2025 March 2025 April 2025 May 2025 June 2025 July 2025 August 2025 September 2025 October 2025 November 2025 December 2025 January 2026 February 2026
Forth Valley - % seen within 18 weeks
Target
SCOT % seen within 18 weeks

February 2026 compliance with the RTT target was 76.6% continuing a relatively consistent position of performance at around 70% compliance or above since June 2024. Monthly fluctuations are related to seasonal variation with peak holiday periods and winter illnesses adversely impact the numbers of people starting therapy with a clinician; the timing of therapeutic groups which enable a large number of people to start therapy simultaneously; and staff turnover.

In April 2025 waiting list projections were requested by Scottish Government and produced by Public Health Scotland on NHS Forth Valley's behalf. These indicated that it would be extremely challenging to meet the RTT target without significant investment in additional resource.

May 2025 through to November 2025 has seen a reduction in numbers waiting for assessment which reflects service improvement work focusing on ensuring that all referrals accepted to the service met clear referral criteria, with referrals which did not meet criteria being redirected to more appropriate services. Improvement work within the service, including managing referral demand and rolling out Waiting Well calls is projected to positively impact the numbers of people waiting for an assessment by the end of this quarter. The total waiting list size for treatment had been slowly reducing since the introduction of an Improvement Plan in May 2025.

Patients that have been waiting an extended period are those with the most complex needs which require specific therapies that are delivered over a longer than average period and can only be delivered by the most highly trained professionals within the multi-professional service. Approval has been given to fund some additional capacity to deliver clinical sessions from January to March 2026. These sessions will be solely for those who have been waiting longest. This, in combination with a new clinical psychologist commencing in January after a period of vacancy, will support a reduction in the number of long waiting patients by the end of March.

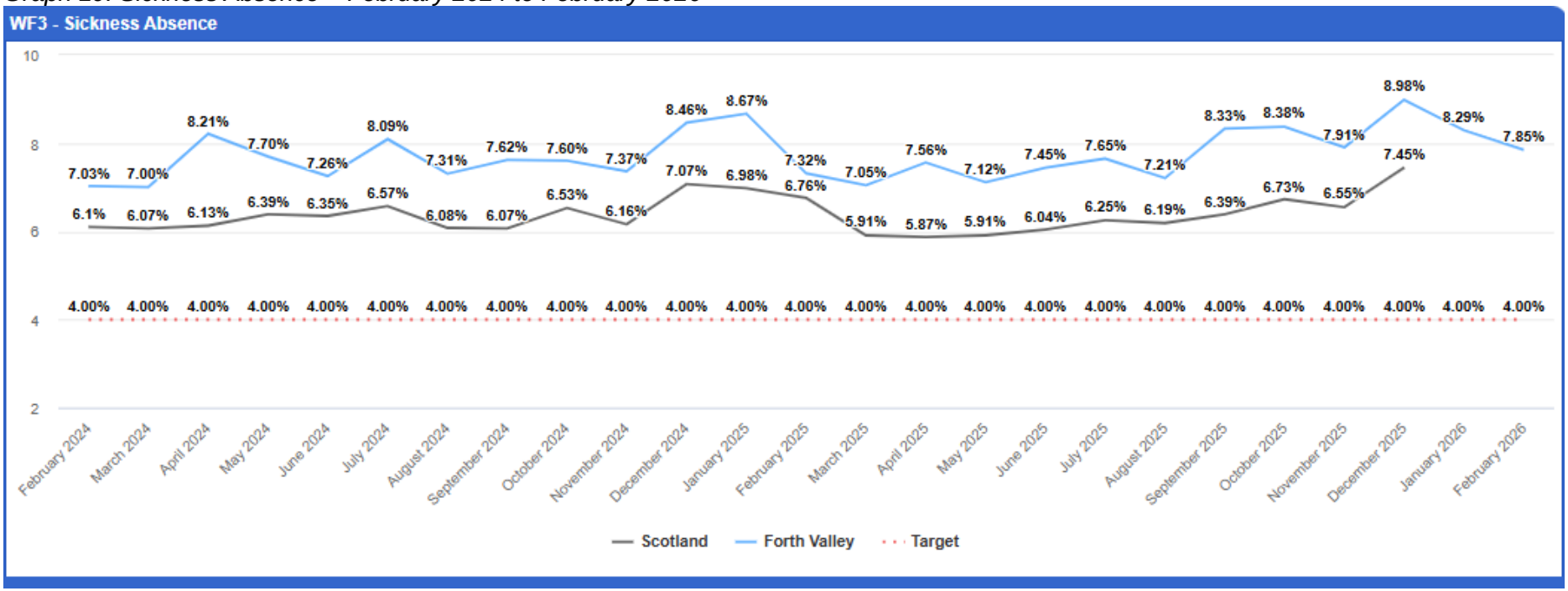
Section 3: Performance Report - Other Areas of Performance

Workforce

To reduce sickness absence to 4%

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Overall Absence	28-Feb-26	4.0%	7.85%	8.29%	7.32%	▼	7.45%	31-Dec-25
Rolling 12 mth	Overall Absence	31-Jan-26	-	7.81%	7.84%	7.67%	▼	6.40%	31-Dec-25

Graph 19: Sickness Absence – February 2024 to February 2026



The sickness absence target is 4.0%. Absence remains above the target at 7.85% in February 2026 noting deterioration from 7.32% in February 2025. The 12-month rolling average February 2025 to January 2026 is noted as, NHS Forth Valley 7.81%; Scotland 6.40%. Anxiety/stress/depression/other psychiatric illnesses are consistently the most reported reason for sickness absence with Cold/Cough/Flu the second highest reason.

The management of absence and the improvement of staff wellbeing remain key priorities for NHS Forth Valley noting a 2% reduction in absence has been included in the Executive Leadership Team objectives. This issue is being addressed through Directorate reviews and through the Whole System Leadership Team.

Work to improve attendance is focussed on the 3 key areas of Attendance Management, Occupational Health and Staff Wellbeing. The launch of the new Workforce Wellbeing Framework 2025-2029 is intended to ensure a comprehensive and coordinated approach to enabling and supporting the wellbeing and mental health of our workforce. In addition, an Attendance Management Plan has been developed in partnership with staff side colleagues with regular progress updates to the Staff Governance Committee

A range of Occupational Health clinical services are providing staff with pathways to counselling, psychology, physiotherapy, management and self-referrals to align with Once for Scotland Policies. Awareness sessions, aimed at improving managers ability to make more accurate referrals to OH clinical pathways are delivered regularly to educate managers through a Management Referral training package. A proactive Occupational Health consultation advice line is established and increases a person-centred approach to enable individuals with access the right care at the right time.

Issues in relation to sickness absence and workforce continue to be examined and discussed at the bi-monthly Staff Governance Committee.

Unavailability

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Outpatient Unavailability	28-Feb-26	Monitor	0.5%	0.4%	0.7%	▲	1.0%	31-Dec-25
Monthly	Inpatient/Day case Unavailability	28-Feb-26	Monitor	4.3%	3.7%	2.7%	▼	3.9%	31-Dec-25

Monitoring of patient unavailability is an Audit Scotland recommendation and refers to the percentage of outpatient or inpatient/daycase unavailability as a proportion of the total waiting list size.

- Outpatient unavailability in February 2026 was 0.5% of the total waiting list.
- Inpatient/daycase unavailability in February 2026 was 4.3% an increase from 2.7% in February 2025. The unavailability rate is less than 6% for most specialties except Surgical Paediatrics (7.14%), Oral and Maxillofacial (6.96), General Surgery (6.73%), Orthopaedics (6.34%) and Vascular Surgery (6.06%). The highest in terms of numbers are Orthopaedics with 161 patients unavailable and General Surgery with 53 patients unavailable.

Did Not Attend (DNA)

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	New Acute Services Outpatient % DNA	28-Feb-26	5%	4.8%	4.7%	4.6%	▼	6.5%	31-Dec-25
Monthly	Return Acute Services Outpatient % DNA	28-Feb-26	5%	4.5%	4.6%	5.2%	▲	-	-

The new outpatient DNA rate across acute services in February 2026 is noted as 4.8% which is a decrease from the position in February 2025 of 4.6%. Variation across specialties continues with rates ranging from 12.5% to 0%. The biggest impact in terms of the number of DNAs can be seen in Orthopaedics 6.6% (76 patients).

The return outpatient DNA rate across acute services in February 2026 was 4.5%. There continues to be a high number of DNAs in Ophthalmology with 217 patients (3.72%), Orthopaedics 89 patients (4.24%), Dermatology 88 patients (4.24%) and Diabetes 81 patients (7.33%).

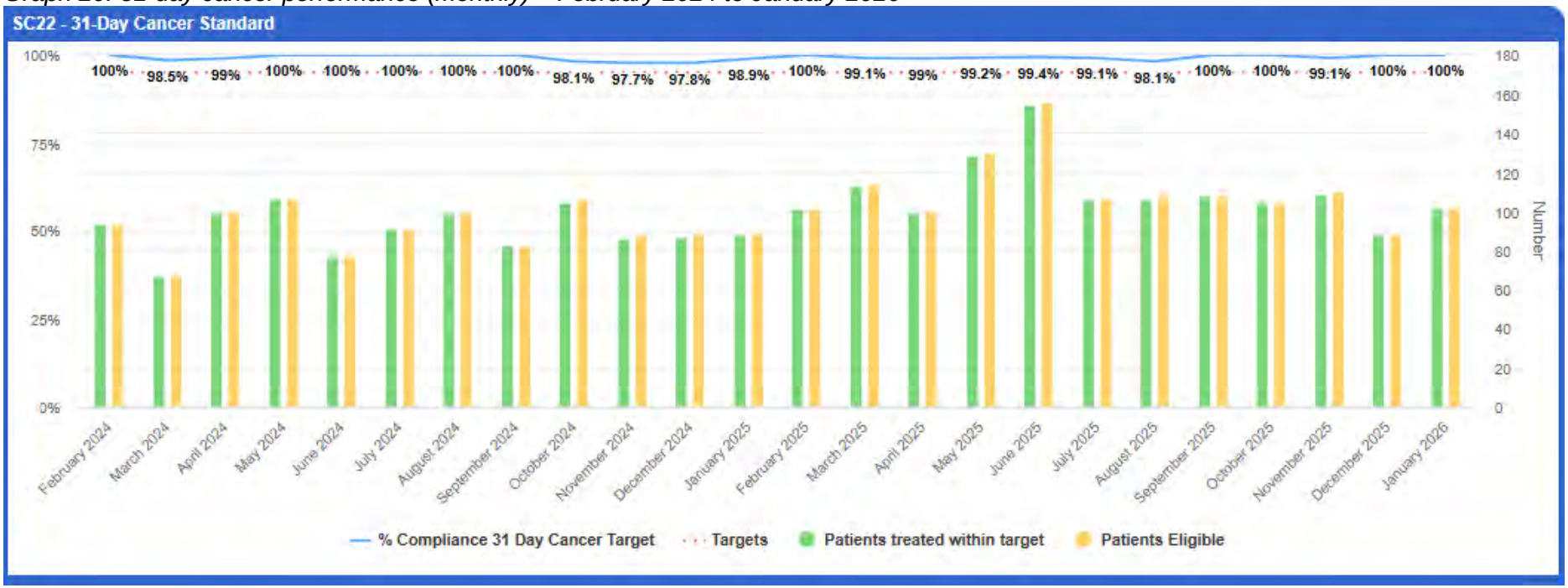
A number of actions are ongoing to support a reduction in the number of DNAs including the roll out of patient focus booking. Application of the Access Policy is actively supported and there is ongoing benchmarking against national DNAs and removal rates. Patient information provides detail on the process to cancel or change an appointment with the relevant contact information.

31- Day Cancer Standard

The 31-day standard states that 95% of all patients should wait no more than 31 days from decision to treat to first cancer treatment.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	31 Day Cancer Target - Percentage compliance against target	31-Jan-26	95%	100.0%	100.0%	98.9%	▲	93.2%	31-Jan-26
Monthly	31 Day Cancer Target - Number seen within target against total	31-Jan-26	-	102/102	88/88	88/89	-	-	-
Quarterly	31 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	99.7%	99.1%	97.9%	▲	95.5%	31-Dec-25

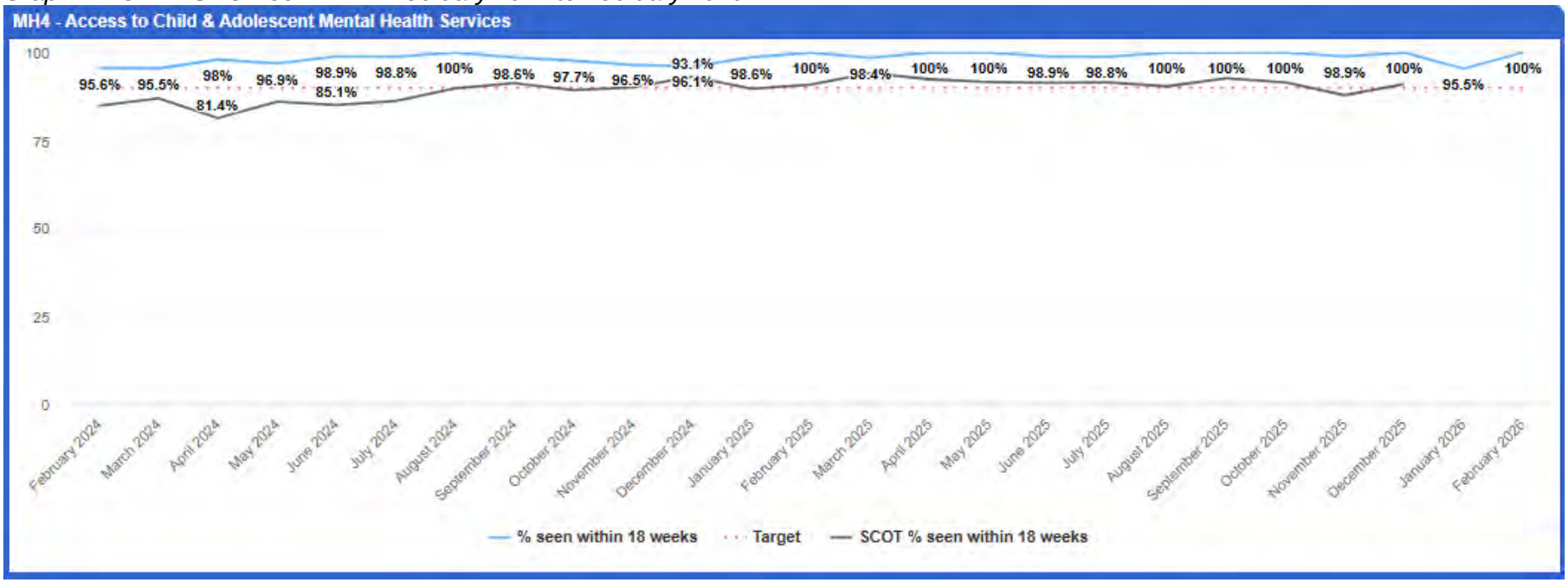
Graph 20: 31-day cancer performance (monthly) – February 2024 to January 2026



Child & Adolescent Mental Health Services (CAMHS)

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Child & Adolescent Mental Health Services - 18 week RTT compliance	28-Feb-26	90%	100.0%	95.5%	100.0%	◄►	90.9%	31-Dec-25
Monthly	Total Number Waiting for CAMHS Initial Assessment	28-Feb-26	Reduction	283	196	50	▼	-	-
Quarterly	Child & Adolescent Mental Health Services - 18 week RTT compliance	31-Dec-25	90%	99.5%	99.4%	96.8%	▲	90.0%	31-Dec-25

Graph 21: CAMHS 18-week RTT – February 2024 to February 2026



February 2026 numbers show we are continuing to perform above target with 100% of patients started treatment within 18 weeks of referral.

Section 4: Performance Scorecard

BETTER CARE													
REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	RUN CHART	NOTES
HOSPITAL STANDARDISED MORTALITY RATE													
MR1	SG	Rolling 12 mth	Hospital Standardised Mortality Ratio (HSMR)	30-Sep-25	</= 1.00	0.94	0.92	0.98	▲	1.00	30-Sep-25	-	Hospital Standardised Mortality Ratio (HSMR) is a measure of mortality adjusted to take account of some of the factors known to affect the underlying risk of death. The data is calculated on a rolling 12 months and published quarterly.
UNSCHEDULED CARE													
	FV	Monthly	Total Number of ED Attendances	28-Feb-26	Reduction	4,763	5,424	4,634	▼	-	-	-	Number of ED attandances and a target of 'Reduction' is relevant in relation to capacity and flow. National standard for A&E waiting times is that unplanned and new planned attendances at an A&E service should be seen and then admitted, transferred or discharged within four hours. This standard applies to all areas of emergency care such as EDs, assessment units, minor injury units, community hospitals, anywhere where emergency care type activity takes place. The measure is the proportion of all attendances that are admitted, transferred or discharged within four hours of arrival. 95% of patients should wait no longer than four hours from arrival to admission, discharge or transfer for A&E treatment.
US1	SG	Monthly	Number of ED Attendances (4 hour access target)	28-Feb-26	Reduction	4,763	5,424	4,634	▼	-	-	-	
US2	SG	Monthly	Emergency Department % compliance against 4 hour access target	28-Feb-26	95%	46.9%	45.0%	50.5%	▼	61.2%	31-Jan-26	✓	
US3	S5	Monthly	Number that waited >4 hours in ED	28-Feb-26	Reduction	2,527	2,985	2,292	▼	-	-	-	
US4	SG	Monthly	Number that waited >8 hours in ED	28-Feb-26	Reduction	1,264	1,526	953	▼	-	-	-	
US5	SG	Monthly	Number that waited >12 hours in ED	28-Feb-26	Reduction	582	784	381	▼	-	-	-	
US6	SG	Monthly	Number that waited >23 hours in ED	28-Feb-26	Reduction	57	150	11	▼	-	-		
	FV	Monthly	Total Number of MIU Attendances	28-Feb-26	Reduction	1,469	1,506	1,475	▲	-	-	-	
US7	SG	Monthly	Number of MIU Attendances (4 hour access target)	28-Feb-26	Reduction	1,469	1,506	1,461	▲	-	-	-	
US8	SG	Monthly	Minor Injuries Unit % compliance against 4 hour target	28-Feb-26	95%	99.5%	99.9%	99.9%	▼	-	-	-	
US9	SG	Monthly	NHS Forth Valley Overall % compliance against 4 hour target	28-Feb-26	95%	59.3%	56.9%	62.3%	▼	65.1%	31-Jan-26	✓	
US12	FV	Monthly	Number of Rapid Assessment and Care Unit New Attendances	28-Feb-26	-	437	521	454	-	-	-	-	
US13	FV	Monthly	Number of Rapid Assessment and Care Unit Scheduled Return Attendances	28-Feb-26	-	145	171	121	-	-	-	-	
US14	FV	Monthly	Number of Re-directions from ED	28-Feb-26	-	498	615	474	-	-	-	-	Redirections from ED to a more suitable setting enabling receipt of the right care, in the right place at the right time
US15	FV	Monthly	Re-directions from ED %	28-Feb-26	-	10.5%	11.3%	10.2%	-	-	-	-	
US16	FV	Monthly	Number of Emergency Admissions	28-Feb-26	Reduction	3,130	3,602	3,117	▼	-	-	-	Admission to a hospital bed following an attendance at an A&E service.
OUT OF HOURS													
OH1	FV	Monthly	Number of Out of Hours Presentations	28-Feb-26	Reduction	4,407	5,887	4,003	▼	-	-	-	
	FV	Monthly	Advice	28-Feb-26	-	2,941	3,995	2,763	-	-	-	-	
	FV	Monthly	Attend OOH Appointment	28-Feb-26	-	1,231	1,567	986	-	-	-	-	
	FV	Monthly	Home Visit	28-Feb-26	-	197	297	168	-	-	-	-	
	FV	Monthly	Mental Health	28-Feb-26	-	36	27	39	-	-	-	-	
	FV	Monthly	SAS In Attendance	28-Feb-26	-	0	0	43	-	-	-	-	
	FV	Monthly	Remote Consultation	28-Feb-26	-	2	1	4	-	-	-	-	
OH2	FV	Monthly	Out of Hours % Rota Fill	28-Feb-26	-	97%	99%	98%	▼	-	-	-	

SCHEDULED CARE												
OUTPATIENTS												
SC1	SG	Monthly	Total Number of New Outpatients Waiting	28-Feb-26	Reduction	18,291	17,599	13,177	▼	-	-	✓	An outpatient is categorised as a new outpatient at his first meeting with a consultant or his representative following an outpatient referral. Outpatients whose first clinical interaction follows an inpatient episode are excluded. Scotland position now monthly for SOT.
			Forth Valley	28-Feb-26	Reduction	17,694	17,074			-	-	-	
			Mutual Aid	28-Feb-26	Reduction	597	525			-	-	-	
SC2	SG	Monthly	Number of New Outpatients waiting over 12 weeks	28-Feb-26	Reduction	7,415	7,023	3,845	▼	-	-	✓	
			Forth Valley	28-Feb-26	Reduction	7,035	6,730			-	-	-	
			Mutual Aid	28-Feb-26	Reduction	380	293			-	-	-	
		Monthly	Number of New Outpatients waiting over 52 weeks	28-Feb-26	0	113	209	194	▲	-	-	✓	
			Forth Valley	28-Feb-26	0	52	67						
			Mutual Aid	28-Feb-26	0	61	142						
SC3	SG	Monthly	New Outpatients waiting under 12 weeks %	28-Feb-26	95%	59.5%	60.1%	70.8%	▼	43.4%	31-Jan-26	✓	
			Forth Valley	28-Feb-26	95%	60.2%	60.6%			-	-	-	
			Mutual Aid	28-Feb-26	95%	36.3%	44.2%			-	-	-	
SC6	Audit	Monthly	Outpatient Unavailability	28-Feb-26	Monitor	0.5%	0.4%	0.7%	▲	1.0%	31-Dec-25	✓	Unavailability, for patients without a date for treatment, is a period of time when the patient is unavailable for treatment. Unavailability can be for medical or social reasons. Scotland position quarterly
SC7	FV	Monthly	New Acute Services Outpatient % DNA	28-Feb-26	5%	4.8%	4.7%	4.6%	▼	6.5%	31-Dec-25	-	A patient may be categorised as did not attend (DNA) when the hospital is not notified in advance of the patient's unavailability to attend on the offered admission date, or for any appointment. Scotland position quarterly
SC8	FV	Monthly	Return Acute Services Outpatient % DNA	28-Feb-26	5%	4.5%	4.6%	5.2%	▲	-	-	-	
DIAGNOSTICS - Imaging													
SC10	SG	Monthly	Total number waiting - Imaging	31-Jan-26	Reduction	3,916	4,495	5,978	▲	-	-	-	Waiting times standard is that patients should be waiting no more than six weeks for one of the eight key diagnostic tests and investigations - Xray, Ultrasound, CT, MRI, Colonoscopy, Upper Endoscopy, Lower Endoscopy, Cystoscopy. Scotland position monthly, available quarterly
SC11	SG	Monthly	Number waiting beyond 42 days - Imaging	31-Jan-26	0	1,082	1,583	2,975	▲	-	-	-	
SC12	SG	Monthly	Percentage waiting less than 42 days - Imaging	31-Jan-26	100%	72.4%	64.8%	50.2%	▲	62.1%	31-Dec-25	✓	
DIAGNOSTICS - Endoscopy													
SC15	SG	Monthly	Total number waiting - Endoscopy	31-Jan-26	Reduction	501	449	914	▲	-	-		
SC16	SG	Monthly	Number waiting beyond 42 days - Endoscopy	31-Jan-26	0	47	46	339	▲	-	-	-	
SC17	SG	Monthly	Percentage waiting less than 42 days - Endoscopy	31-Jan-26	100%	90.6%	89.8%	62.9%	▲	41.8%	31-Dec-25	✓	
CANCER													
SC20	SG	Monthly	62 Day Cancer Target - Percentage compliance against target	31-Jan-26	95%	77.8%	66.2%	74.4%	▲	69.9%	31-Jan-26	✓	Cancer services remain a priority for scheduled care. All Urgent Suspicion of Cancer referrals are tracked to support achievement of the 62 and 31 day access targets. In areas where this is not reached priority measures are taken to address this. A robust monitoring system has been established to identify reasons for breaches and ensure a plan is in place to prevent further non-compliance. The 62-day standard states that 95% of eligible patients should wait no longer than 62 days from urgent suspicion of cancer referral to first cancer treatment. The 31-day standard states that 95% of all patients should wait no more than 31 days from decision to treat to first cancer treatment.
SC21	SG	Monthly	62 Day Cancer - Number seen within target against total	31-Jan-26	-	63/81	43/65	58/78	-	-	-	-	
	SG	Monthly	62 Day Cancer - Breast - Percentage compliance against target	31-Jan-26	95%	100.0%	100.0%	100.0%	▲	89.3%	31-Jan-26	-	
	SG	Monthly	62 Day Cancer - Breast - Number seen within target against total	31-Jan-26	-	17/17	9/9	3/3	-	-	-	-	
	SG	Monthly	62 Day Cancer - Colorectal - Percentage compliance against target	31-Jan-26	95%	92.9%	66.7%	81.8%	▲	73.9%	31-Jan-26	-	
	SG	Monthly	62 Day Cancer - Colorectal - Number seen within target against total	31-Jan-26	-	13/14	4/6	9/11	-	-	-	-	
	SG	Monthly	62 Day Cancer - Cervical - Percentage compliance against target	31-Jan-26	95%	n/a	100.0%	0.0%	▲	78.6%	31-Jan-26	-	
	SG	Monthly	62 Day Cancer - Cervical - Number seen within target against total	31-Jan-26	-	0/0	1/1	0/1	-	-	-	-	
	SG	Monthly	62 Day Cancer - Head & Neck - Percentage compliance against target	31-Jan-26	95%	100.0%	75.0%	50.0%	▲	79.5%	31-Jan-26	-	
	SG	Monthly	62 Day Cancer - Head & Neck - Number seen within target against total	31-Jan-26	-	2/2	3/4	2/4	-	-	-	-	
	SG	Monthly	62 Day Cancer - Lung - Percentage compliance against target	31-Jan-26	95%	81.8%	72.7%	78.6%	▲	84.1%	31-Jan-26	-	
	SG	Monthly	62 Day Cancer - Lung - Number seen within target against total	31-Jan-26	-	9/11	8/11	11/14	-	-	-	-	
	SG	Monthly	62 Day Cancer - Lymphoma - Percentage compliance against target	31-Jan-26	95%	100.0%	100.0%	100.0%	▲	84.0%	31-Jan-26	-	
	SG	Monthly	62 Day Cancer - Lymphoma - Number seen within target against total	31-Jan-26	-	1/1	1/1	4/4	-	-	-	-	
	SG	Monthly	62 Day Cancer - Melanoma - Percentage compliance against target	31-Jan-26	95%	100.0%	100.0%	100.0%	▲	80.0%	31-Jan-26	-	
	SG	Monthly	62 Day Cancer - Melanoma - Number seen within target against total	31-Jan-26	-	1/1	5/5	5/5	-	-	-	-	
	SG	Monthly	62 Day Cancer - Ovarian - Percentage compliance against target	31-Jan-26	95%	100.0%	n/a	100.0%	◄►	81.3%	31-Jan-26	-	
	SG	Monthly	62 Day Cancer - Ovarian - Number seen within target against total	31-Jan-26	-	1/1	0/0	2/2	-	-	-	-	
	SG	Monthly	62 Day Cancer - Upper GI - Percentage compliance against target	31-Jan-26	95%	81.8%	88.9%	91.7%	▼	85.1%	31-Jan-26	-	
	SG	Monthly	62 Day Cancer - Upper GI - Number seen within target against total	31-Jan-26	-	9/11	8/9	11/12	-	-	-	-	
	SG	Monthly	62 Day Cancer - Urology - Percentage compliance against target	31-Jan-26	95%	43.5%	21.1%	50.0%	▼	40.5%	31-Jan-26	-	
	SG	Monthly	62 Day Cancer - Urology - Number seen within target against total	31-Jan-26	-	10/23	4/19	11/22	-	-	-	-	
SC22	SG	Monthly	31 Day Cancer Target - Percentage compliance against target	31-Jan-26	95%	100.0%	100.0%	98.9%	▲	93.2%	31-Jan-26	✓	
SC23	SG	Monthly	31 Day Cancer Target - Number seen within target against total	31-Jan-26	-	102/102	88/88	88/89	-	-	-	-	
SC24	SG	Quarterly	62 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	70.3%	85.9%	79.2%	▼	71.7%	31-Dec-25	✓	
SC25	SG	Quarterly	31 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	99.7%	99.1%	97.9%	▲	95.5%	31-Dec-25	✓	

INPATIENTS & DAYCASES													
SC26	SG	Quarterly	Number of patients that waited >12 weeks - Completed Wait	31-Dec-25	0	1,847	2,054	1,386	-	-	-	-	
SC27	SG	Quarterly	% Compliance with 12 week TTG Standard	31-Dec-25	100%	35.4%	33.6%	44.6%	▼	58.6%	31-Dec-25	-	
SC28	SG	Monthly	Total Number of Inpatients/Day cases Waiting	28-Feb-26	Reduction	7,578	7,782	6,873	▼	-	-	✓	
			Forth Valley	28-Feb-26	Reduction	7,265	7,346		-	-	-	-	
			Mutual Aid	28-Feb-26	Reduction	58	75		-	-	-	-	
			NTC	28-Feb-26	Reduction	255	361		-	-	-	-	
SC29	SG	Monthly	Number of Inpatients/Day cases waiting over 12 weeks	28-Feb-26	Reduction	5,062	5,026	4,475	▼	-	-	✓	
			Forth Valley	28-Feb-26	Reduction	4,819	4,703		-	-	-	-	Treatment Time Guarantee (TTG) - There is a 12 week maximum waiting time for the treatment of all eligible patients who are due to receive planned treatment delivered on an inpatient or day case basis. Scotland position quarterly
			Mutual Aid	28-Feb-26	Reduction	35	24		-	-	-	-	
			NTC	28-Feb-26	Reduction	208	299		-	-	-	-	
		Monthly	Number of Inpatients/Day cases waiting over 52 weeks	28-Feb-26	0	265	367	645	▲	-	-	✓	
			Forth Valley	28-Feb-26	0	218	324		-	-	-	-	
			Mutual Aid	28-Feb-26	0	19	1		-	-	-	-	
			NTC	28-Feb-26	0	28	42		-	-	-	-	
SC30	SG	Monthly	Percentage of Inpatients/Day cases waiting under 12 weeks	28-Feb-26	100%	33.2%	35.4%	34.9%	▼	36.3%	31-Dec-25	✓	
			Forth Valley	28-Feb-26	100%	33.7%	36.0%		-	-	-	-	
			Mutual Aid	28-Feb-26	100%	39.7%	68.0%		-	-	-	-	
			NTC	28-Feb-26	100%	18.4%	17.2%		-	-	-	-	
SC33	Audit	Monthly	Inpatient/Day case Unavailability	28-Feb-26	Monitor	4.3%	3.7%	2.7%	▼	3.9%	31-Dec-25	✓	Unavailability, for patients without a date for treatment, is a period of time when the patient is unavailable for treatment. Unavailability can be for medical or social reasons. Scotland position quarterly.
READMISSIONS													
R1	FV	Monthly	Readmissions - Surgical 7 day	28-Feb-26	Reduction	2.4%	3.0%	3.3%	▲	-	-	-	
R2	FV	Monthly	Readmissions - Surgical 28 day	28-Feb-26	Reduction	6.6%	5.9%	7.0%	▲	-	-	-	This is the measure of patients readmitted as an emergency to a medical/surgical specialty within 7 days or 28 days of the index admission. Emergency readmissions as a percentage of all admissions.
R3	FV	Monthly	Readmissions - Medical 7 day	28-Feb-26	Reduction	1.3%	1.3%	1.2%	▼	-	-	-	
R4	FV	Monthly	Readmissions - Medical 28 day	28-Feb-26	Reduction	3.8%	3.5%	3.6%	▼	-	-	-	
MENTAL HEALTH													
PSYCHOLOGICAL THERAPIES													
MH1	SG	Monthly	Psychological Therapies - 18 week RTT compliance	28-Feb-26	90%	76.6%	69.1%	73.8%	▲	84.7%	31-Dec-25	✓	
MH2	FV	Monthly	Total Number Waiting for Pyschological Therapies Initial Assessment	28-Feb-26	Reduction	1053	956	985	▼	-	-	-	
MH3	SG	Quarterly	Psychological Therapies - 18 week RTT compliance	31-Dec-25	90%	74.1%	77.1%	74.8%	▼	82.1%	31-Dec-25	✓	
CHILD & ADOLESCENT MENTAL HEALTH SERVICES													The 18 Weeks RTT is a whole journey waiting time standard from initial referral to the start of treatment. The standard has been determined by the Scottish Government and states that 90.0% of patients should have a completed pathway within 18 weeks.
MH4	SG	Monthly	Child & Adolescent Mental Health Services - 18 week RTT compliance	28-Feb-26	90%	100.0%	95.5%	100.0%	◄►	90.9%	31-Dec-25	✓	
MH5	FV	Monthly	Total Number Waiting for CAMHS Initial Assessment	28-Feb-26	Reduction	283	196	50	▼	-	-	-	
MH6	SG	Quarterly	Child & Adolescent Mental Health Services - 18 week RTT compliance	31-Dec-25	90%	99.5%	99.4%	96.8%	▲	90.0%	31-Dec-25	✓	
SUBSTANCE USE													
SM1	SG	Quaterly	% Compliance with the 3 Week target - ADP (excluding Prisons)	30-Sep-25	90%	100.0%	100.0%	99.5%	▲	94.7%	30-Sep-25	✓	The Scottish Government set a Standard that 90% of people referred for help with problematic drug or alcohol use will wait no longer than three weeks for specialist treatment that supports their recovery.
SM2	SG	Quaterly	% Compliance with the 3 Week target - Prisons	30-Sep-25	90%	100.0%	98.5%	93.5%	▲	93.9%	30-Sep-25	✓	
COMPLAINTS													
C1		Monthly	% Compliance Forth Valley (inc. prisons)	31-Jan-26	100%	84.1%	80.1%	66.5%	▲	-	-	✓	Complaints monitoring and feedback is a standing item on the Clinical Governance Committee agenda
C2		Monthly	% Compliance Stage 1 (inc. prisons)	31-Jan-26	100%	88.5%	92.0%	66.0%	▲	-	-	✓	
C3		Monthly	% Compliance Stage 2 (inc. prisons)	31-Jan-26	100%	57.9%	43.9%	13.3%	▲	-	-	✓	

REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	RUN CHART	
BETTER WORKFORCE													
WF3	SG	Monthly	Overall Absence	28-Feb-26	4.0%	7.85%	8.29%	7.32%	▼	7.45%	31-Dec-25	✓	Hours lost due to sickness absence / total hours available (%). Short Term Absence - a period of sickness absence of 28 days or less Long Term Absence - a period of sickness absence lasting over 28 days Absence Management is a standing item on the Staff Governance Committee agenda.
WF4	FV	Monthly	Short Term Absence	28-Feb-26	-	2.74%	2.97%	2.48%	▼	-	-	-	
WF5	FV	Monthly	Long Term Absence	28-Feb-26	-	5.11%	5.33%	4.84%	▼	-	-	-	
WF6	FV	Rolling 12 mth	Overall Absence	31-Jan-26	-	7.81%	7.84%	7.67%	▼	6.40%	31-Dec-25	-	
BETTER VALUE													
REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	RUN CHART	
DELAYED DISCHARGES													
VA1	FV	Monthly	Delayed Discharges - excl. Code 9 & Guardianship (Standard Delays)	28-Feb-26	Reduction	53	56	78	▲	-	-	✓	A delayed discharge is a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning that patient's discharge, and who continues to occupy the bed beyond the ready for discharge date
			Falkirk	28-Feb-26	Reduction	36	32	51	▲	-	-	✓	
			Clackmannanshire	28-Feb-26	Reduction	6	7	9	▲	-	-	✓	
			Stirling	28-Feb-26	Reduction	9	15	13	▲	-	-	✓	
			Outwith Forth Valley	28-Feb-26	Reduction	2	2	5	▲	-	-	✓	
VA2	FV		Code 9 & Guardianship Delays	28-Feb-26	Reduction	51	59	44	▼	-	-	✓	
			Falkirk	28-Feb-26	Reduction	16	25	22	▲	-	-	✓	
			Clackmannanshire	28-Feb-26	Reduction	11	13	11	◄►	-	-	✓	
			Stirling	28-Feb-26	Reduction	22	19	6	▼	-	-	✓	
			Outwith Forth Valley	28-Feb-26	Reduction	2	2	5	▲	-	-	✓	
VA3	FV		Total Bed Days Occupied by Delayed Discharges (Standard Delays)	28-Feb-26	Reduction	2,146	1,644	2,436	▲	-	-	✓	
			Falkirk	28-Feb-26	Reduction	1,528	1,073	1,724	▲	-	-	✓	
			Clackmannanshire	28-Feb-26	Reduction	121	181	188	▲	-	-	✓	
			Stirling	28-Feb-26	Reduction	474	352	292	▼	-	-	✓	
			Outwith Forth Valley	28-Feb-26	Reduction	23	38	232	▲	-	-	✓	
VA4	FV	Daily	Number waiting for a Community Bed	28-Feb-26	Reduction	32	46	43	▲	-	-	-	
AVERAGE LENGTH OF STAY													
VA4	FV	Monthly	FVRH Acute Wards Average Length of Stay (Days)	28-Feb-26	Reduction	6.41	5.91	7.12	▲	-	-	-	This is the mean length of stay (in days) experienced by inpatients in FVRH Acute wards, does not include MH or W&C.
EFFICIENCY													
E1	FV	Monthly	ED Attendances per 100,000 of the population - Forth Valley	28-Feb-26	Reduction	1,573	1,792	1,531	▼	-	-	-	
E2	FV	Rolling 12 mth	Acute Emergency Bed days per 1,000 population - Forth Valley	28-Feb-26	Reduction	672	745	898	▲	-	-	-	
E3	FV	Monthly	% Bed Occupancy - FVRH	28-Feb-26	Reduction	104.7%	105.2%	113.6%	▲	-	-	-	The percentage occupancy is the percentage of average available staffed beds that were occupied by inpatients during the period. 85% is the nationally agreed standard supporting optimum flow
E4	FV	Monthly	% Bed Occupancy - Assessment Units	28-Feb-26	Reduction	83.4%	85.8%	107.2%	▲	-	-	-	
E5	FV	Monthly	% Bed Occupancy - ICU	28-Feb-26	Reduction	72.6%	90.2%	102.1%	▲	-	-	-	

EQUITABLE													
EQ1		Rolling 3 year	Scottish Breast Screening Programme	2020/23	70%	76.4%	74.4%	76.4%	◄►	75.9%	2020/23	-	Percentage uptake (three-year rolling periods), females aged 50-70 years
EQ2		Annually	Scottish Cervical Screening Programme	2023/2024	-	66.9%	66.3%	72.5%	▼	63.3%	2023/24	-	The percentage of eligible women who are up-to-date with their screening participation
EQ3		Rolling 2 year	Scottish Bowel Screening Programme	2022/24	60%	66.2%	66.6%	66.6%	▼	65.7%	2022/24	-	Overall uptake of screening - percentage of people with a final outright screening test result, out of those invited (2 year reporting period)
EQ4		Annually	Scottish Abdominal Aortic Aneurysm (AAA) screening programme	2023/24	75%	73.4%	24.1%	24.1%	▲	77.3%	2023/24	-	Percentage of eligible population who are tested before age 66 and 3 months
		Annually	Surveillance AAA scan (quarterly)	2023/24	90%	100.0%	84.4%	81.0%	▲	94.3%	2023/24	-	Due to attend quarterly surveillance and tested within 4 weeks of due date
		Annually	Surveillance AAA scan (annually)	2023/24	90%	91.8%	84.4%	84.4%	▲	94.4%	2023/24	-	Due to attend annual surveillance and tested within 6 weeks of due date
EQ5		Quarterly	NHS stop smoking services: Local Delivery Plan (LDP) - Number of 12-week quits	31-Mar-25	87	57	51	79	▼	-	-	-	The LDP Standard for NHS Scotland in 2024/25 is to achieve at least 7,026 self-reported successful twelve-week quits through smoking cessation services in the 40% most deprived areas
EQ6		Quarterly	NHS stop smoking services: 12-week quits as a % of the LDP Quarterly Target	31-Mar-25	100%	66.0%	59.0%	91.1%	▼	64.0%	31-Dec-24	-	
FINANCE													
F1	SG	FYTD	Year to date revenue position	28-Feb-26	Breakeven	-£1.274m	-£1.856m	-£2.5m	▲	-	-	-	

Scorecard Detail	
Target Type	FV - Local target/measure set and agreed by NHS Forth Valley; SG - Target/measure set by Scottish Government
Frequency	Frequency of monitoring in relation to scorecard
Measure	Brief description of the measure
Date	Date measure recorded
Target	Agreed target position
Current Position	As at date
Previous Reporting Period	Previous year, quarter, month, week or day dependent on frequency of monitoring
Previous Year	Same reporting period in previous year
Run Chart	✓ - indicates run chart associated with measure is available
Key to Direction of travel	▲ - Improvement in period or better than target
	▼ - Deterioration in period or below target
	◄► - Position maintained
Scotland Position	Scotland measure
Scotland Frequency	Frequency of Scotland measure
Notes	

Forth Valley NHS Schedule of Business 2026/27								
		28 April	**16 June (Private)**	**30 June – tbc**	**25 August**	**27 October**	**15 December**	**23 February**
Standing Items	**Lead**							
Minute of previous meeting	Chair	☑	☑		☑	☑	☑	☑
Action Log	Chair	☑			☑	☑	☑	☑
Chair's Update	Chair	☑			☑	☑	☑	☑
Board Seminar Update (reported to next available Board meeting)	Chair	☑			☑	☑	☑	
Board Executive Team Report	Chief Executive	☑			☑	☑	☑	☑
Strategic Risk Register	Head of Risk	☑			☑	☑	☑	☑
Spotlight on Services / Patient/Staff Story	END	☑			☑	☑	☑	☑
Finance Report	DoF	☑			☑	☑	☑	☑
Performance Report	DoSPP	☑			☑	☑	☑	☑
Healthcare Associated Infection Reporting Template	END	☑			☑	☑	☑	☑
Quality & Safety Report	END / MD	☑			☑	☑	☑	☑
Schedule of Business	BSec	☑			☑	☑	☑	☑
Minutes	Comm. Chair							
Assurance Committee Minutes	Comm. Chair	☑			☑	☑	☑	☑
Advisory Committees Minutes	Comm. Chair	☑			☑	☑	☑	☑
IJB Minutes: C & S and Falkirk	Comm. Chair	☑			☑	☑	☑	☑
Finance								
Annual Accounts	DoF		☑					
Draft Financial Plan 2026/2027	DoF							☑
Performance								
HSCP Annual Performance Reports	Chief Offs						☑	
Person Centred Complaints Feedback Annual Report	END					☑		
Safe Staffing Annual Report	END	☑						
Whistleblowing Annual Report	END							☑
Whistleblowing Standards and Activity Report	END				☑		☑	
Strategy								
Access Policy	DoA							
Annual Delivery Plan	DoSPP				☑			
Climate Emergency & Sustainability Strategy and Action Plan 2023-2026 – Annual Update	DoFacilities					☑		
Communications Priorities	Head of Comms	☑						

Communications Update	Head of Comms				☑			☑
Digital and eHealth Plan	DoD	☑						
Equality Outcomes and Mainstreaming Annual Report – tbc	DoP							
Innovation Plan Annual Update	MD				☑			
Mental Health & Wellbeing Strategic Commissioning Plan	C&S Chief Officer				☑			
Participation & Engagement Strategy Update	Head of Comms							
Quality Strategy Annual Update	MD				☑			
Shifting the Balance of Care Business Case / Whole System Urgent & Unscheduled Care Plan	DoA Chief Officers							☑
Stirling Children's Services Annual Report					☑			
Whole System Plan – tbc								
Winter Plan	DoA						☑	
Governance								
Board Assurance Framework – Annual Review (including Performance Framework)	DoSPP							
Code of Corporate Governance – Annual Review	BSec	☑						
Corporate Objectives	Chief Executive							☑
Corporate Objectives 2025/26 Progress Update	Chief Executive				☑			☑
Dates of Meetings	BSec					☑		
Development Plan Against Self-Assessment Progress Report	Chair				☑			
Statutory and national quality reports, including updates informed by HIS, Audit Scotland or other external scrutiny bodies where applicable.	As appropriate	As required						